A Call for Action

THE PEPPER COMMISSION

U.S. Bipartisan Commission
on Comprehensive Health Care

Final Report

September 1990

LAW
RA
395
A3
U514
1990

RA
395
.A3
U514
1990
c.2

ERRATA

A Call for Action

THE PEPPER COMMISSION

U.S. Bipartisan Commission
on Comprehensive Health Care

Final Report

September 1990

S. PRT. 101-114

Printed for the use of the Pepper Commission

U.S. GOVERNMENT PRINTING OFFICE
28-860 WASHINGTON : 1990

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, DC 20402

THE PEPPER COMMISSION

U.S. Bipartisan Commission on Comprehensive Health Care

SENATOR JOHN D. ROCKEFELLER IV, West Virginia, Chairman

House of Representatives

FORTNEY PETE STARK, California, Vice Chairman
BILL GRADISON, Ohio, Vice Chairman
MARY ROSE OAKAR, Ohio
LOUIS STOKES, Ohio
THOMAS TAUKE, Iowa
HENRY WAXMAN, California

Senate

MAX BAUCUS, Montana, Vice Chairman
DAVE DURENBERGER, Minnesota, Vice Chairman
JOHN HEINZ, Pennsylvania
EDWARD M. KENNEDY, Massachusetts
DAVID PRYOR, Arkansas

Presidential Appointees

JAMES BALOG
JOHN COGAN
JAMES DAVIS, M.D.

Staff Members

Judith Feder, Staff Director
Edward F. Howard, General Counsel

Steven C. Edelstein
Tiffany Ericksen
Robert B. Friedland
Janis E. Guerney
Monica E. McFadden
Philip Shandler

Robyn I. Stone
Dessa Vrtikapa
Judith G. Waxman
S. Mitchell Weitzman
Joy Johnson Wilson

There was an error in Figure B-1 on page 269 in the second column. The key was transposed.

Appendix B

Health Care and Long-Term Care Options

In developing its recommendations on health care and long-term care, the Commission carefully evaluated a variety of options. To understand the full reasoning behind the Commission's choices, it is useful to review the alternatives the Commission considered and ultimately rejected. All cost estimates are for 1990 and assume full implementation in that year.

HEALTH CARE

Two alternatives to the Commission approach that are often proposed to ensure health care coverage for all Americans are (1) expanding public coverage for the poor and helping others purchase private insurance on a voluntary basis, and (2) replacing the current job-based system with national health insurance. The Commission evaluated these options primarily in terms of the amount of additional coverage they would provide, their disruption of current practices, and their costs to the taxpayer.[1] Table B-1 and Figures B-1 and B-2 compare the options to the Commission's recommendations.

Expanding Public and Promoting Private Coverage

Most options for helping people obtain health insurance involve providing coverage to the poor and assisting the near-poor to purchase coverage. This combination attempts to expand existing coverage mechanisms to people now left out. It retains the voluntary nature of our current system and enables individuals to make their own choices about health insurance.

The Commission looked at several options to extend coverage to the poor and near-poor—including broadening Medicaid eligibility as well as providing an array of subsidies to small employers and individuals. A variation that illustrates the effect of these approaches would:

- Provide public insurance free to all those whose family income is below poverty;
- Set provider payments at rates set according to Medicare rules, rather than at Medicaid rates;
- Reform the health insurance market to ensure that private insurance is available to all those willing to purchase it;
- Provide a sliding-scale subsidy to those whose family incomes are between poverty and twice poverty so they could purchase private insurance.

This proposal would cost the federal government an estimated $36 billion—$12 billion more than the Commission's proposal—and would cover only about half the currently uninsured. At least 14.4 million Americans would still lack health insurance from any source.

Figure B-1 Comparison of Cost, by Health Insurance Options

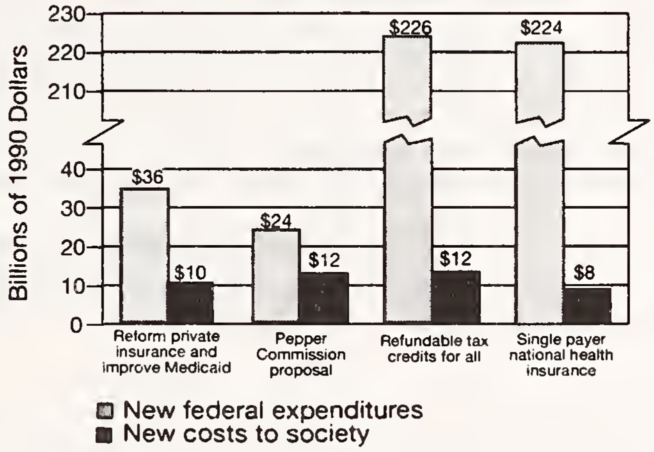
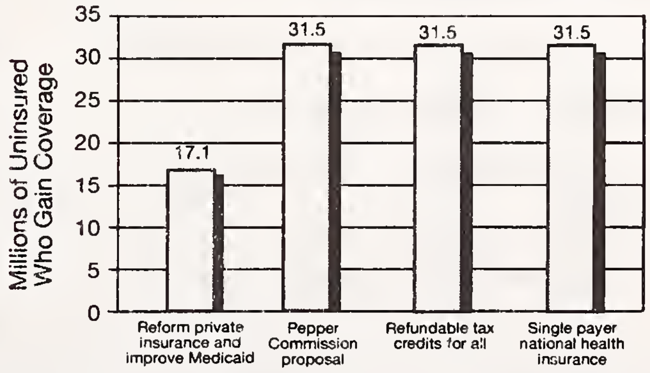


Figure B-2 Comparison of Coverage, by Health Insurance Options



NOTE: 31.5 million people under age 65 now lack health insurance

The limited impact of this proposal on coverage reflects the fact that even subsidies to people with incomes up to twice the poverty level leave insurance beyond the means of many who are now uninsured. Subsidies may not be sufficient to make coverage affordable for the near-poor, and people with incomes above twice the poverty level would get no help with insurance costs.[2] A family of three with an income of about $20,000 (twice the poverty standard), for example, could face insurance costs exceeding 10 percent of their income.

The new federal costs are relatively high because coverage would be extended to many workers and their families who could obtain job-based coverage if their employers provided it. More than half the uninsured are workers or in families of workers with family incomes below twice the poverty level.

This approach also raises the concern that employers might drop the coverage they provide if their employees could obtain it elsewhere. The more generous the subsidy, the more likely that behavior becomes. If low-income people who now have job-based insurance were to use Medicaid or the subsidies, federal costs could increase by another $15.6 billion.[3]

The net new cost to society of covering about 17 million of the uninsured (the sum of the net costs to the federal government, and savings to state governments and individuals) would be $10 billion, or $585 per newly insured person.[4, 5] This compares with net new costs to society of $12 billion under the Commission recommendations for almost 32 million uninsured ($381 per newly insured person).

The Commission rejected this approach for three reasons. First, it would not ensure adequate health insurance for all Americans. Half of today's uninsured would remain uninsured, and the underinsured would not be helped at all.

Second, because the federal government would absorb the full costs for low-income workers, taxpayers would have to pay substantially more than the job-based approach the Commission recommends. Further, it threatens to unravel the coverage employers now provide—shifting costs from employers to taxpayers.

Third, without universal coverage it would be impossible either to eliminate uncompensated care or to stop the cost shifting from those without coverage to those with it. Larger employers, who pay for much of this cost shifting, would not benefit from this proposal.

Replacing the Current System

The Commission considered replacing the job-based connection to health insurance—that is, replacing the mechanism by which 75 percent of all workers and their dependents now obtain health insurance—with two very different approaches to national health insurance. These were a refundable tax credit provided to everyone for the purchase of private health insurance and a single-payer, federally run national health insurance system.

Table B-1 Options for Health Insurance Coverage: Costs and Distribution

(In Billions of 1990 Dollars)

Option	Net New Federal Expenditure	Net New State and Local Expenditures	Net New Private Expenditures	Net New Health Costs to Society	New Costs to Society per Newly Insured (In dollars)
I. Expanded Medicaid plus subsidies for private insurance	$36	($4)	($22)	$10	$585
Americans without health insurance = 14.4 million					
II. Pepper Commission Proposal	24	(7)	(5)*	12	381
Americans without health insurance = 0					
III. Refundable Tax Credit for all Americans	226	(7)	(207)	12	381
Americans without health insurance = 0					
IV. Single payer national health insurance	224	(7)	(209)	8	254
Americans without health insurance = 0					

* Employers who now provide health insurance will save $12.8 billion. Employers who now do not provide health insurance will spend an additional $27.5 billion. Individuals will save $19.3 billion in out-of-pocket and premium expenses.

SOURCE: Staff estimates reviewed by John Sheils of Lewin/ICF and Kenneth Thorpe of Harvard School of Public Health.

A Call for Action

THE PEPPER COMMISSION

U.S. Bipartisan Commission on Comprehensive Health Care

Final Report

September 1990

S. Prt. 101–114

Printed for the use of the Pepper Commission

U.S. GOVERNMENT PRINTING OFFICE
28-860 WASHINGTON : 1990

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, DC 20402

THE PEPPER COMMISSION

U.S. Bipartisan Commission on Comprehensive Health Care

SENATOR JOHN D. ROCKEFELLER IV, West Virginia, Chairman

House of Representatives

FORTNEY PETE STARK, California, Vice Chairman
BILL GRADISON, Ohio, Vice Chairman
MARY ROSE OAKAR, Ohio
LOUIS STOKES, Ohio
THOMAS TAUKE, Iowa
HENRY WAXMAN, California

Senate

MAX BAUCUS, Montana, Vice Chairman
DAVE DURENBERGER, Minnesota, Vice Chairman
JOHN HEINZ, Pennsylvania
EDWARD M. KENNEDY, Massachusetts
DAVID PRYOR, Arkansas

Presidential Appointees

JAMES BALOG
JOHN COGAN
JAMES DAVIS, M.D.

Staff Members

Judith Feder, Staff Director
Edward F. Howard, General Counsel

Steven C. Edelstein
Tiffany Ericksen
Robert B. Friedland
Janis E. Guerney
Monica E. McFadden
Philip Shandler

Robyn I. Stone
Dessa Vrtikapa
Judith G. Waxman
S. Mitchell Weitzman
Joy Johnson Wilson

September 1990

Dear colleague,

In P.L. 100-360 the Congress called upon the Pepper Commission to recommend legislation that would ensure all Americans coverage for health care and long-term care. With this report, the Commission fulfills that charge and calls upon you—our colleagues in the Congress, the President, and the American people—to turn its recommendations into law.

The Commission's intensive efforts to develop recommendations have not been an academic exercise. This report presents a workable plan of action to address the rapidly growing crisis in health and long-term care. To agree on that plan, Commission members have had to make hard choices and compromise strongly held positions. Members who believed action was critical refused to allow their personal vision of the best to become the enemy of the good.

In health care, a workable plan means we have no choice but to build universal coverage by reforming and extending the job-based and public coverage we now have to make it work well for all Americans. In long-term care it means we must establish priorities to build the protection we now lack. And in both areas, we must build deliberately, a step at a time, to allow all parties to adjust and to ensure a sound and stable structure.

Some will say that it is naive to pursue even such worthwhile social investments in the current fiscal environment. But there will never be a day when the answers become easy or cheap. There will never be a day when all of us can have our first choice or ideal solution. There will never be a day when some of us will not have to make some sacrifices to achieve what is best for all of us.

As the nation's political leaders, we face a choice: we can continue to duck our heads and hope this issue will not bring the nation to its knees, or we can use the Commission recommendations as the rallying point for the political consensus that can make universal coverage in an efficient system a reality.

I urge you to join with me in pursuing the latter course—not only because it can work but because it is the only responsible means to take action we know is imperative. The recommendations presented here provide the tools we need to build a health and long-term care system we can all be proud of. Now we must put those tools to work.

Sincerely,

Jay Rockefeller

John D. Rockefeller IV
Chairman

In Memory Of The Honorable Claude Pepper

> *My dear friends, this is an opportunity that will be rare for us in our legislative experience . . . when you go home tonight and you close your eyes and you sleep and you ask, "What have I done today to lighten the burden upon those who suffer," at least you could say, "I helped a little bit today; I voted to help those who needed help."*
>
> *—Claude Pepper, floor statement*
> *on his home care proposal,*
> *U.S. House of Representatives,*
> *June 8, 1988*

Acknowledgements

The deliberations and recommendations of the Pepper Commission would not have been possible without the extensive support of individuals and organizations too numerous to mention. First and foremost, the Commission is indebted to the many individuals who shared the hardships they have faced in obtaining or financing health and long-term care, so that we might benefit from their experience.

Second, a multitude of organizations and individual experts identified problems and proposed specific solutions which influenced the Commission actions.

Third, in its deliberations and preparation of its report, the Commission benefited from the extraordinary expertise and commitment of particular individuals. The Congressional Reference Service contributed invaluable support. Janet Kline, Mark Merlis, Beth Fuchs, and Janet Lundy provided information and analysis throughout the process. Specific analyses were prepared by Richard Price, Carol O'Shaughnessy, Melvina Ford, Ed Klebe, and Jennifer O'Sullivan. Joan Sokolovsky provided valuable research support.

Fourth, as indicated in the supplementary volume to this support, the Commission drew upon numerous agencies and individuals to prepare background materials for the Commission's deliberations. The efforts of the General Accounting Office, the Office of Technology Assessment, and the Department of Health and Human Services are particularly appreciated.

Fifth, the Commission is grateful for the invaluable editorial support provided by Felicity Skidmore and Lynn Lewis, and for the capable production assistance of Leon Stern.

Finally, the analysis presented here would not have been possible without the assistance of numerous consultants. The Commission is particularly appreciative of the efforts of David Kennell, Lisa Alecxih, John Sheils, Marilyn Moon, and Kenneth Thorpe.

Table of Contents

Chapter *Page*

EXECUTIVE SUMMARY 1

1 WHY DO WE NEED HEALTH CARE REFORM? 21
  Who Lacks Health Insurance Protection? 21
    Growth in the Uninsured Population 22
    The Problem of Inadequate Protection 23
  Why Is Protection Lacking? 25
    Problems in Employment-Related Coverage 25
      Firm Size and Industry Differences 25
      The Small Group Health Insurance Market 27
    Defects of Public Health Care Coverage 30
      Medicaid 30
      Other Public Health Coverage Programs 32
  What Care Do the Uninsured Get? 33
    Service Use 34
    Sources of Care for Those Who Cannot Pay 35
      Public Health Programs 36
      Charity Care 37
  Is Our Health Care System in Jeopardy? 38
    Rising Costs 38
    Employer Costs and Responses 38
    Are We Getting Value for Our Dollars? 39
    What Is Appropriate Care? 40
    Malpractice Litigation: Protection or Problem? 41
  Underserved Areas and Special Population Groups 42
    Medically Underserved Areas 43
      Rural Areas 43
      Inner Cities 43
    Special Needs of Special Populations 43
      The Poor 43
      Minorities 43
      High-Risk Pregnant Women and Their Infants 43
      The Geographically Isolated 43
      The Physically and Mentally Handicapped 44
      Others 44
    Current Programs to Address Delivery Barriers 44

2 BLUEPRINT FOR HEALTH CARE REFORM 53
  Summary of Recommendations 54
    Building Universal Coverage 54
    Strengthening the Health Care System 55
    Improving Protection for People 65 and Over 56

Page

Building Universal Coverage 57
  Structure for Coverage 57
  Sharing Financial Responsibilities 58
  Reforming the Private Health Insurance Market 59
  Creating the Federal Public Program 60
  Minimum Benefit Package 61
    Parity with Employer Coverage 62
    Universal Standard Appropriate to Needs of the Uninsured 62
    Cost Sharing Requirements 63
    Preventive Services 63
    Role of Medicaid 63
  Putting Universal Coverage into Effect 63
    Year One 63
    Year Two 64
    Year Three 64
    Year Four 64
    Year Five 64
  Costs, Coverage, and Service Impacts of Commission's Recommendations 65
    Costs to Employers 65
    Impact on Employment 67
    Costs to Individuals 67
    Costs to Government 68
    Impact on the Private Insurance Market 68
    Impact on Service Use 69
Strengthening the Health Care System 69
  Quality Assurance and Malpractice Reform 69
  Cost Containment 73
    Controlling Costs 73
    Reducing Cost Inequities Among Groups 75
  Access for the Underserved 76
    Primary Care Delivery Systems 77
    Adequate Personnel and Services 78
  Preventing Illness and Promoting Health 79
Improving Protection for People 65 and Over 79
  Assisting the Low-Income Elderly 79
  Improving Medicare Benefits 81
  Reforming the Medigap Market 82

3 WHY DO WE NEED LONG-TERM CARE REFORM? 89
What Is Long-Term Care? 90
Who Needs Long-Term Care? 91
  The People 91
  Where People Live 91
How People Get and Pay for Care 92
  Caring for People at Home 93
    Informal Care 93
    Purchasing Care 95
    Public Programs 95
  Nursing Home Care 100
    Medicare 101
    Medicaid 102
The Role of Private Long-Term Care Insurance 104
  Development of the Market 104
  Future Prospects for the Market 106

Page
Prospects for the Future 108
Changing Needs 108
Capacity to Respond 108

4 BLUEPRINT FOR LONG-TERM CARE COVERAGE FOR ALL AMERICANS 119
Summary of Recommendations 120
The Public Program 121
Who Is Eligible for Public Benefits 121
How People Become Eligible 122
Benefits and Financial Responsibilities 122
Home and Community-Based Care Benefits 122
Nursing Home Care 124
Financing of the Public Plan 126
Administering the Public Plan 126
Ensuring Quality and Containing Costs 127
Integration with Existing Federal Long-Term Care Programs 128
Phase-In Schedule for the Public Program 128
Year One 128
Year Two 128
Year Three 128
Year Four 128
The Role of Private Long-Term Care Insurance 129
Research Agenda 129
Beneficiaries and Costs of Commission Recommendations 130

5 REVENUES TO FINANCE COMMISSION RECOMMENDATIONS 137
Progressive Taxes 137
Growth 137
Contributions from Everyone 137
Revenue Sources and Options 137

VOTE TALLIES AND COMMISSIONERS' VIEWS

VOTE TALLIES 141

COMMISSIONERS' VIEWS 143

APPENDIXES

A COMMISSION ACTIVITIES, MAY 1989–MARCH 1990 261

B HEALTH CARE AND LONG-TERM CARE OPTIONS 269

C COST IMPACTS FOR LARGE AND SMALL BUSINESSES 279

D ASSUMPTIONS USED TO ESTIMATE COSTS FOR HEALTH CARE RECOMMENDATIONS 283

E ASSUMPTIONS USED TO ESTIMATE COSTS FOR LONG-TERM CARE RECOMMENDATIONS 289

F REVENUE OPTIONS 301

LIST OF TABLES

Chapter *Page*

1 WHY DO WE NEED HEALTH CARE REFORM?

1–1 Nonelderly Uninsured Persons, by Age, Sex, and Race/Ethnicity, 1987 22
1–2 Family Income Distribution of Nonelderly Population Without Health Insurance, 1987 23
1–3 Work Force Connections of the Uninsured, 1987 24
1–4 Examples of Industries Ineligible for Health Insurance Under Selected Insurer Plans 27

2 BLUEPRINT FOR HEALTH CARE REFORM

2–1 Percentage of Firms Paying More Than 80 Percent of Employee Health Premiums 62
2–2 Benefits: Commission Plan Compared with Current Employer Practices 62
2–3 Cost Sharing: Commission Plan Compared with Current Employer Practices 63
2–4 Phase-In Schedule and Cost of the Commission's Health Care Proposals 66
2–5 Impact of Commission Plan on Health Care Spending, by Source 67
2–6 Impact of Commission Plan on Employers Who Now Provide Health Insurance 67
2–7 Impact of Commission Plan on Employers Who Do Not Provide Health Insurance 68
2–8 Impact of Commission Plan on Individual Health Insurance Expenditures 68
2–9 Impact of Commission Plan on Federal Expenditures 69
2–10 Coverage Under Public and Job-Based Private Health Insurance, Alternative Tax Rates 70
2–11 Impact of Commission Plan on Health Care Expenditures by Type of Service for Noninstitutionalized People 71
2–12 Impact of Proposal to Expand Protection for the Low-Income Elderly Population, 1990 81

3 WHY DO WE NEED LONG-TERM CARE REFORM?

3–1 National Long-Term Care Expenditures, by Source, 1988 93

4 BLUEPRINT FOR LONG-TERM CARE COVERAGE FOR ALL AMERICANS

4–1 Beneficiaries and Net Federal Costs of Commission Long-Term Care Recommendations, by Age Group and Type of Service 130
4–2 Phase-In Schedule and Cost of Commission Long-Term Care Plan 131
4–3 Coverage for Elderly Nursing Home Entrants with Long Stays Under Commission Plan 132

LIST OF FIGURES

Chapter *Page*

1 WHY DO WE NEED HEALTH CARE REFORM?

1–1 Distribution of Nonelderly Uninsured, by Age, 1987 22
1–2 Percentage of Nonelderly People Without Insurance, by Age, 1987 23
1–3 Distribution of Nonelderly Uninsured, by Family Income as a Percentage of Poverty, 1987 23
1–4 Work Force Connections of the Uninsured and Their Dependents, 1987 24
1–5 Trends in the Uninsured Population and Unemployment Rates (In Percent) 24
1–6 Percentage of Firms with Health Insurance Plans, by Firm Size, 1986 25
1–7 Uninsured Workers, by Firm Size, 1987 25
1–8 Workers and Source of Health Insurance, by Firm Size, 1987 27
1–9 Average Reported Physician Contacts, by Income and Insurance, 1986 35
1–10 Average Reported Hospital Inpatient Days, by Income and Insurance Status, 1986 35

2 BLUEPRINT FOR HEALTH CARE REFORM

2–1 Public-Private Split of New Worker Coverage Under Commission Plan 69
2–2 Distribution of the General Population and the Elderly Population, by Income Relative to Poverty Level, 1988 80
2–3 Medigap Loss Ratios for Individual Policies Offered by Selected Commercial Insurers, 1988... 82

3 WHY DO WE NEED LONG-TERM CARE REFORM?

3–1 People Needing Long-Term Care, Including the Severely Disabled, by Age 91
3–2 Residence of People Needing Long-Term Care 92
3–3 Residence of the Severely Disabled 93
3–4 People Needing Long-Term Care and Expenditures for Long-Term Care, by Place of Residence 95
3–5 Sources of Payment for Nursing Home Care, 1988 95
3–6 Source of Home Care Services for the Severely Disabled Elderly Population, 1989 97
3–7 Informal Caregivers of Disabled Elderly in the Community, 1984 97
3–8 Distribution of Out-of-Pocket Health and Long-Term Care Costs for Elderly with More Than $3,000 in Direct Expenditures, 1985 102
3–9 Number of Elderly Needing Long-Term Care, 1990 and 2030 108

4 BLUEPRINT FOR LONG-TERM CARE COVERAGE FOR ALL AMERICANS

4–1 How Commission Plan Benefits Elderly Nursing Home Entrants, Compared with Current Law 131
4–2 Number of Beneficiaries of Commission Long-Term Care Plan, by Income Relative to Federal Poverty Level 132

Executive Summary

Executive Summary

Our health care system still inspires awe—and rightly so. Americans should be proud of a system that can provide the best care in the world.

But our system also creates fear—among the millions already excluded from it and the increasing numbers at risk of exclusion:

- Uninsured pregnant women, without the resources to seek prenatal care;
- Workers who are ill, with preexisting conditions that may cost them their health insurance if they change jobs;
- Workers in small businesses, for whom a sudden illness can put insurance premiums out of reach for the entire firm;
- Workers with good coverage, who see their benefits threatened each time they go to the bargaining table;
- Families whose emotional and financial resources are exhausted from providing long-term care to frail parents or disabled children.

Finally, our system breeds frustration—among the many who seek ways to reform it and resolve its problems.

Most reformers agree that our health care system should cover all Americans. But to do so, some would replace the system. Others would reshape it, often in dramatically different ways. People and institutions criticize and ultimately reject initiatives that differ from their ideal or that—in their view—move too fast or too slowly. If their first choice is unattainable, the second choice for many is to do nothing.

Public policy is paralyzed. The fear and the flaws continue.

The Pepper Commission calls for action to end that paralysis with recommendations for legislation that would guarantee all Americans coverage for health and long-term care within a system that both ensures quality and contains costs.

To develop these recommendations, the Commission intensively investigated the problems and alternative actions to address them. It listened to numerous witnesses in public hearings held in the nation's capital and around the country. It heard from experts in health and long-term care. In the process the Commission gathered a wide range of views from consumers, employers, workers, providers, insurers, and numerous organizations and groups. Then its members met in a series of working sessions to consider all these views, clarify their own objectives, and develop recommendations to achieve them.

Based on a shared view that current conditions are unconscionable and that public action is urgent, the Commission unanimously agreed that all Americans should have access to affordable health and long-term care coverage in an efficient and effective system.

> ***"Allowing these health and long-term care problems to persist not only deprives millions of Americans of what they ought to be able to have . . . it diminishes our economy. . . . [and] . . . the United States of America. I don't think it's possible to say . . . that we are a civilized nation when so many of our people . . . do not have long-term care, do not have health insurance."***
>
> ***—Senator John D. Rockefeller IV***

After further intense debate, the majority of the Commission adopted specific recommendations to achieve this goal. These recommendations reflect the view that we must begin to build universal health care coverage now. We must pursue the workable rather than the ideal. We must secure and improve the health care system for all Americans, including those currently left out. And we must create a long-term care system that serves our nation's severely disabled and addresses the deepest fears of Americans—elderly and nonelderly—about their future should they become disabled and need long-term care.

This report lays out the problems the Commission believes the nation must solve and the Commission's blueprint to guarantee all Americans affordable, high-quality health care and long-term care when they need it. With this blueprint before us, we can build universal coverage a step at a time.

Because today's system works differently for health care (primarily physician and hospital services) than for long-term care, the discussion and the recommendations address each separately. Although health problems cannot be so neatly segmented, this is simply the most pragmatic way to discuss building a system based on what we now have.

WHY DO WE NEED HEALTH CARE REFORM?

The American health care system is approaching a breaking point. Rapidly rising medical costs are increasing the numbers of people without health coverage and straining the system's capacity to provide care for those who cannot pay. The gap is widening between the majority of Americans, who can take advantage of the best medical services in the world, and the rest, who find it hard to get even basic needed care. As the gap increases, the weight of financing care for those without adequate coverage is undermining the stability of our health institutions. Even for the majority, the explosive growth in health care costs is steadily eroding the private insurance system—the bulwark they count on as their defense against financial risk in case of illness.

> ***"[The] American health care system . . . [is] a paradox of plenty and of want, a system where some receive the benefit of the most advanced medical technologies in the world, yet many poor women can't get decent prenatal care and families can't get help to keep a frail parent from having to go into a nursing home."***
>
> *—Senator Dave Durenberger*

Who Is Uninsured and Why?

Most Americans of working age get insurance for themselves and their dependents through their jobs. But not all of us work—and not all employers provide insurance. People who fail to obtain job-based coverage may also be excluded from Medicaid and other public programs because of restrictive eligibility rules. Consequently, almost 32 million Americans under 65 lack health care coverage of any kind. That's nearly 15 percent of our nonelderly population. Another 20 million have inadequate coverage. And the proportion who are uninsured was 20 percent greater in the 1980s than in the 1970s.

Anyone can become uninsured—regardless of age, income, or employment status. A close look at the problem shows what kinds of people are falling through the cracks (see Figures 1 and 2):

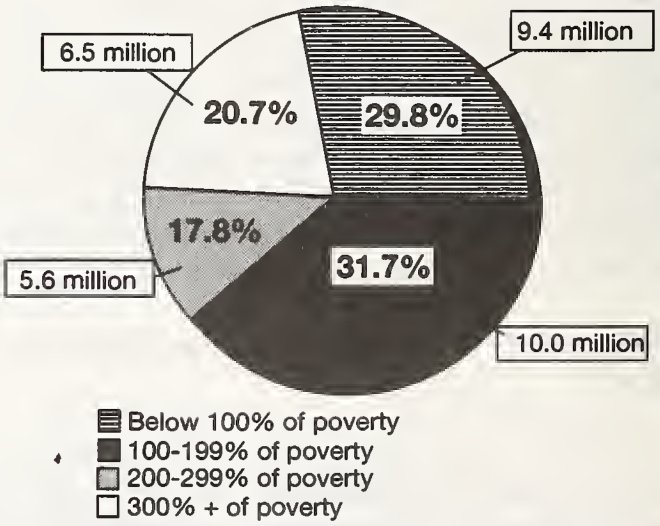
- Many of the uninsured are young. In 1987, nearly half were under 25, and more than 28 percent were under 18.
- Most of the uninsured are poor or near-poor. In 1987, one-third were in families with incomes below the federal poverty level ($11,611 for a family of four). Two-thirds were in families with incomes below twice the poverty level.
- Most of the uninsured are directly or indirectly attached to the work force. Three-quarters of the uninsured are workers or their dependents.

These characteristics of the uninsured raise two key questions about our country's health care coverage.

- Why doesn't job-based health insurance reach all workers and their families?
- Why does the public safety net fail to protect the poor?

Uninsured Workers—Firms of all sizes have uninsured workers, but workers in smaller firms are much less likely to get insurance through their jobs (see Figure 3). In 1987, just over half of uninsured

Figure 1 **Distribution of Nonelderly Uninsured, by Family Income as a Percentage of Poverty, 1987**



SOURCE: Lewin/ICF analysis of Current Population Survey data, March 1988.

MIKE MCGARVIN/HOLY CROSS CLINIC AT POVERELLO HOUSE

Almost 9 million children are uninsured—more than one- quarter of all those without public or private protection.

workers were in firms with fewer than 25 employees. Even though most small firms provide insurance to their workers, large numbers do not—increasingly because they are disadvantaged in the insurance market.

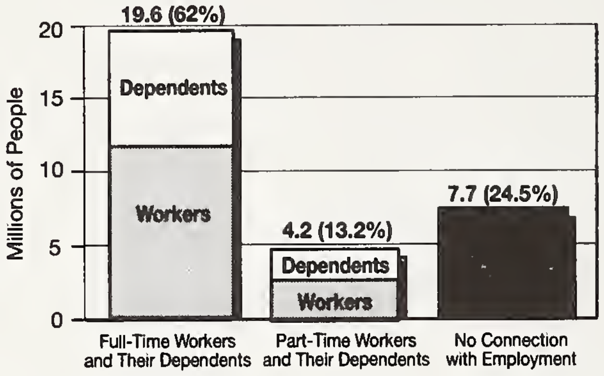
Small firms must pay more for insurance than large firms because they have fewer employees among whom to spread administrative costs and any losses for extremely costly enrollees. Small firms thought to present high risks pay even higher rates, and are often forced to exclude certain employees or certain conditions. They are sometimes unable to obtain coverage at any price.

Insurance practices that make it hard for small employers to obtain coverage are the byproduct of today's competitive market. So long as any insurer engages in assessing the risks of each individual in a group (medical underwriting) and group-specific rating, others must follow suit or risk losing all but the highest-cost groups. Without reform of the insurance market, the problem will only get worse.

Coverage of the Poor—Coverage for the nation's poor is largely the responsibility of the Medicaid program, a federal/state entitlement program administered by the states under broad federal guidelines. Medicaid has accomplished a great deal. But Medicaid does not reach more than a fraction of the low-income population. In 1987, the program assisted only 42 percent of those with incomes below the poverty line. Even among the extremely poor (family incomes below 25 percent of poverty) nearly a quarter are not covered by Medicaid or any other program.

The poor must meet two kinds of tests to receive Medicaid assistance. First, they must fall into one of the categories of persons traditionally eligible for cash

Figure 2 Work Force Connections of the Uninsured and Their Dependents, 1987*



*Under 65 Population

SOURCE: Lewin/ICF analysis of Current Population Survey data, March 1988.

assistance or welfare: the aged, disabled, or members of families with children. Completely omitted from the program, even if they are literally penniless, are single people and childless couples under 65 who do not meet disability tests. Second, applicants must meet financial standards imposed by the states. For many covered groups there are no federal requirements to prevent states from setting shockingly low standards. In Alabama, for example, a family of three qualified for Medicaid in 1990 only if its income was less than 13 percent of the federal poverty guidelines.

Moreover, because states have failed to increase their income eligibility levels to keep pace with inflation, Medicaid programs are covering smaller proportions of the poor. Even recent congressional efforts to expand coverage for pregnant women and young children—severing eligibility for Medicaid from eligibility for cash welfare—appear to have been largely offset by declining coverage among older children and other groups. Finally, in an effort to control costs, states frequently limit both the services covered and the payments made to providers for covered services. The result: inadequate access to service.

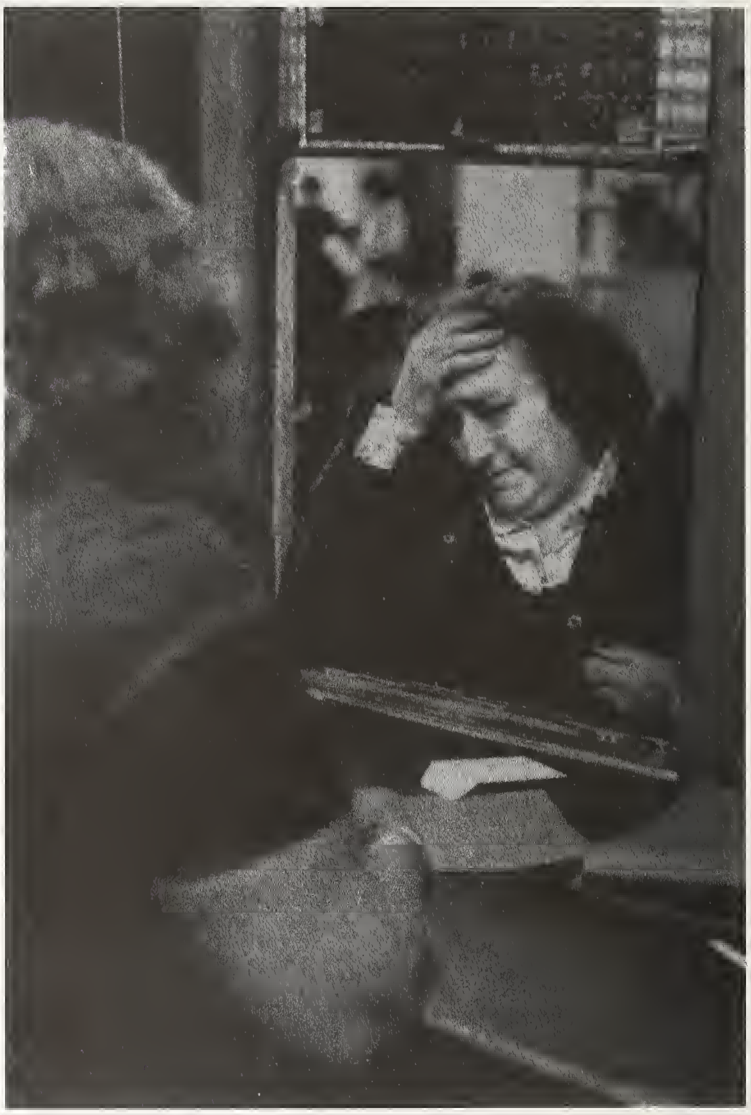
Some states have tried to fill in with programs of their own. But funding limitations and other problems have prevented these programs from reaching more than a few of the millions of poor people lacking health coverage.

Without major changes in public policy, Medicaid and supplemental programs will never reach all the poor. Protection will vary considerably from state to state. And many low-income Americans will go without health care coverage even in the more generous states.

Who Cares for the Uninsured?

Care for the uninsured poses two fundamental problems. First, people lacking insurance may go without care when they need it. Second, the costs for the care they do receive are unfairly distributed among other groups, straining critical elements of the nation's health care system.

Barriers to Care—The Commission heard heartbreaking testimony about care foregone or delayed; a substantial body of evidence demonstrates that the witnesses were not presenting isolated or unique cases. A 1986 nationwide survey found that uninsured people with serious symptoms saw physicians only half as often as similarly ill people who had insurance. Other studies show comparable results.



EARL DOTTER

Faced with costs they cannot pay, the uninsured delay or do not get medical care.

Often the uninsured delay care for minor or chronic problems until those problems become serious or acute. To the human costs of being uninsured, then, must be added the economic costs of the patterns of care that result.

Financing Care for the Uninsured—Who pays for this care? Although government programs provide some help for people who cannot afford to pay, the insured population foots much of the bill. Providers of care cover their losses on uninsured patients from their charges to those who can pay—primarily the privately insured. For hospitals this cost shifting totaled $8.3 billion in 1988.

Cost shifting has long been regarded as a hidden tax on those with insurance, much of which is paid by the employers who offer insurance, in effect, to pay for the workers of employers who do not.

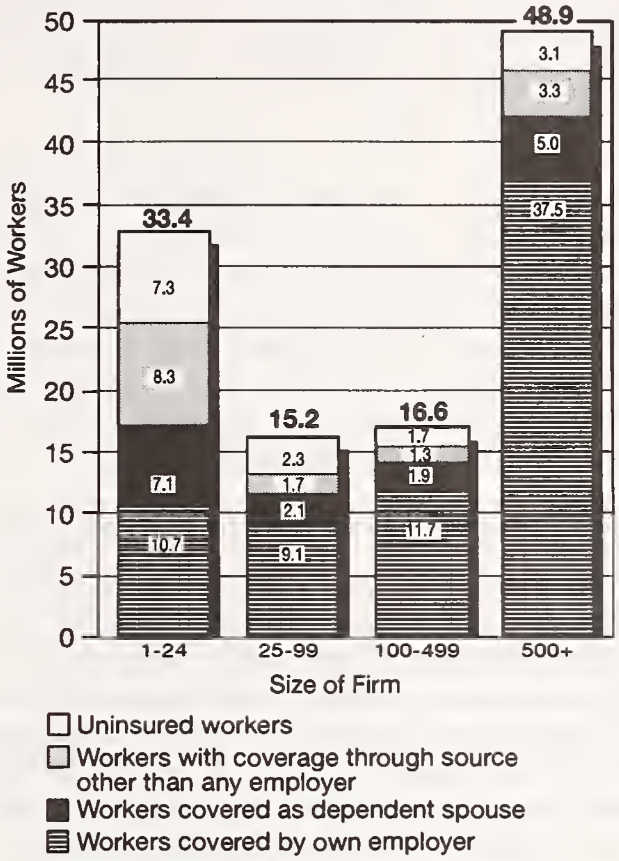
Increasingly, employers and insurers are finding ways to avoid this hidden tax at the same time as the need for care is rising. Along with a greater number of uninsured people, the nation is experiencing a rise in costly social problems like drug abuse, AIDS, violent crime, and low birthweight babies—problems that require expensive care. Some hospitals are responding to squeezed resources by eliminating trauma centers and emergency rooms, which are most likely to attract those who cannot pay. These services are then lost to the entire community, causing everyone to travel farther for urgent care.

Is Health Care for the Insured In Jeopardy?

For the majority of Americans with health insurance, the problem of care for the uninsured may seem remote. This is a shortsighted view. As the strains on the system grow, those who depend on job-based coverage face an increasing risk of joining the ranks of the uninsured.

> ***"Health insurance is supposed to be a bridge to security . . . [but] we have a system that's falling apart. The 'on-ramp' has collapsed and a lot of children are having difficulty, uninsured because of the income level of who they're born to. The [Medicare catastrophic] 'off-ramp' has collapsed. . . . The long-term care off ramp has never been open. And the group insurance concept is beginning to break apart, which has been sort of the main body of the bridge. . . . [This Commission] has the responsibility to be the safety engineers and architects and we need a review of the entire system."***
>
> *—J. Robert Hunter, president, National Insurance Consumers Organization*

Figure 3 Workers and Source of Health Insurance, by Firm Size, 1987



SOURCE: Lewin/ICF estimates from Current Population Survey data, March 1988.

Especially threatened are workers in smaller firms. Almost half of the smallest firms still offer insurance to their workers. But their ability to do so is jeopardized by the growing competition among insurers to avoid poor risks. A whole company may lose coverage or see its premiums skyrocket because of the experience of a single individual. Some of these workers may be able to find coverage on their own. But those in poor health may not find coverage at any price, or may only find coverage that excludes the precise condition for which they need care. It makes little sense that hard-working Americans, able and willing to pay, cannot find an insurer that will cover them.

While poor Americans typically face the greatest barriers to insurance coverage, the specter of inadequate insurance and catastrophic medical expenses threatens middle-income Americans as well.

Larger firms do not face problems in the insurance market. Yet their workers, too, are not entirely secure. Their coverage is jeopardized by continuously escalating health care costs. For the country as a whole, health care spending now absorbs 11 percent of the gross national product (GNP) and is projected to absorb 15 percent by the year 2000. For employers, health benefits are equivalent to more than 90 percent of after-tax profits, compared with 74 percent in 1984 and only 14 percent in 1965. Such dramatic increases not only impede efforts to improve access to health care; they are bound to erode the access we now have as employers cut back on coverage. Employees increasingly are paying more of the premium for themselves and their dependents, causing growing numbers to drop coverage.

And as costs continue to rise, Americans are questioning whether we are getting our money's worth. Concerns about the appropriateness and effectiveness of medical procedures, the quality of health care providers, and the problems related to our approach to medical malpractice add to the crisis caused by the burden of unfinanced care. Unless these concerns are addressed, even those who are now well-insured may find their health coverage in jeopardy.

> ***"I view health care finance in this country as a house of cards. You can add cards at the bottom: Medicaid expansions. You can add cards at the top: Medicare catastrophic. It is still a house of cards. A house of cards can stand in a quiet room, but it cannot stand when there is wind. [And] we have the wind of unmet need. . . the wind of public dissatisfaction. . . the wind of demographic change. . . the wind of cost. . . . This house of cards cannot stand in this wind."***
>
> ***—Deborah Steelman, chairman, Advisory Council on Social Security***

BLUEPRINT FOR HEALTH CARE REFORM

The Commission concludes that, in the absence of systemwide reform, the proportion of Americans without adequate health care coverage will grow. The burden of caring for those who cannot pay will overwhelm the system, putting us all at risk of inadequate access to care. As costs continue to rise, more and more dollars will go to services of uncertain value, while millions of people will go without basic and necessary care.

To prevent such a disaster, the Commission unanimously adopted the following goal:

> The Commission is committed to the development of recommendations for public policies that will assure all Americans access to affordable health care coverage that allows them to obtain necessary care and assures them adequate financial protection; that will promote quality care and address the problem of health care costs; and that will provide the financing required to assure access.

Before selecting its preferred course of action, the Commission explored two major alternative strategies to achieve this goal. The first was an expansion of the Medicaid program to cover all the poor plus subsidies to help the near-poor purchase private health insurance. The Commission believes that such an approach would be an inadequate response to the crisis. Even the substantial expansion of public support the Commission considered would leave some 14 million Americans—almost half the uninsured population—without access to affordable coverage. Further, it would fail to provide help to additional millions whose coverage is inadequate. With so many remaining uninsured, cost shifting and the burden of uncompensated care would still mean inequity and instability in the system as a whole. Finally, broadening the public program for the poor but making no requirements on employers would allow employers who do not now provide coverage to continue to shift responsibilities to others. This approach could also reduce employers' willingness to cover low-income employees who are now protected—shifting substantial costs from employers to taxpayers.

The second major alternative the Commission considered was replacing of the current combined job-based and public approach with national health insurance. The Commission is convinced, however, that such a drastic departure from our current system would be controversial and disruptive to the majority of Americans—for whom insurance still works. It would also totally shift fiscal responsibility from employers to taxpayers. Furthermore, movement to a single federal system would eliminate the diversity and choice that many believe, appropriately guided, can increase the strength and flexibility of our health care system.

In order to act now, as we must, the Commission recommends that we build upon and strengthen the existing system of job-based and public coverage to create universal health care coverage. This is, in the Commission's judgment, the most pragmatic strategy for securing adequate health coverage for all Americans.

Combining universal coverage with other federal initiatives to strengthen the health care system can ensure the value for the health dollar and access to quality service, efficiently delivered, that the nation so sorely needs.

Building Universal Coverage

The Commission's blueprint for building a universal job-based/public system of health care coverage has five parts.

1. The Commission believes that employers and the government together should provide a minimum level of health care coverage for workers and nonworkers who, in turn, should be expected to accept that coverage.

Small employers face considerable and increasing obstacles to purchasing affordable health insurance policies for their employees. Other Commission recommendations address the problems of the insurance market (see below). Because of these obstacles, and because it would take time for the insurance market recommendations to take effect, *the Commission recommends that small employers be encouraged through tax credits/subsidies to provide coverage for their employees.*

Large employers do not face such obstacles. *The Commission recommends that, after a period for adjustment, they be required to provide coverage for their employees.*

The subsidies and the insurance market reform should allow small employers to purchase affordable insurance for their workers. If sufficient progress has not been made after several years, *the Commission recommends that small employers become subject to the same requirements as large employers.*

Even if job-based insurance becomes much more widely available, it will never be enough. The unemployed and the poor will need public protection. *The Commission recommends that the federal government provide coverage for these groups by replacing and expanding the role currently performed by states through the Medicaid program.*

When job-based coverage and the federal program are fully implemented and in place, *the Commission recommends that all individuals be required to obtain health care coverage from their employer or from the public program.*

2. The Commission believes that all parties—employers, individuals, and government—should share in financing health care coverage. Requirements for financial participation should not impose excessive burdens on individuals or employers. It is the federal government's responsibility to establish a ceiling on obligations related to ability to pay, and to provide the additional necessary financing. Therefore, *the Commission recommends that the small employers encouraged to provide coverage receive tax credits/subsidies to reduce the costs of private insurance; that employers required to provide coverage be able to obtain it from a federal program for a contribution set at a fixed share of their payroll expenses; and that low-income workers and nonworkers receive subsidies to keep their contributions within reasonable bounds.*

3. The Commission believes that private insurers and government should each play a role in administering health care coverage. But there is a critical need for reforms to strengthen both private and public performance, making coverage not only available but also adequate to ensure access to care. In order to preserve and expand private insurance as the primary source of job-based coverage, *the Commission recommends requirements that would bring an end to the underwriting, rating, and marketing practices that are unraveling private insurance protection for small employers.* At the same time, *the Commission recommends that responsibility for providing public coverage be shifted from states to the federal government, be severed from the welfare system, be uniform across the country, and pay providers at rates determined by Medicare rules.*

4. The Commission believes that universal health care coverage that ensures people access to necessary care must meet an adequate minimum standard. That standard should establish basic protection for the currently uninsured and underinsured and preserve protection for the currently insured into the future. For public and private coverage, *the Commission recommends a federally specified minimum benefit package that includes preventive and primary care as well as other physician and hospital care.* Individuals would be responsible for a share of premiums and service costs—on all but preventive services—up to a maximum and subject to their ability to pay.

5. The Commission believes that action cannot come too soon for the millions without coverage and millions more who see their coverage threatened. However, an effective system cannot be put into place overnight. It will take time to develop and implement.

To balance these concerns, the Commission recommends that the system be put in place a step at a time. The first and most critical step in expanding coverage is to ensure protection for pregnant women and children who are now uninsured and to initiate reforms that reverse the disintegration of the private insurance market for small employers. This would create an environment in which employers would have an opportunity to provide the coverage the Commission expects. The second step, to take place in years two through five of implementation, is to effect a series of incentives and requirements for employer coverage, giving employers time to adjust to their new obligations. The final step, to occur in year five, is to extend the federal government's coverage for all nonworkers.

The Commission believes this sequence of steps allows immediate action to address the most urgent problems and provides an orderly transition to universal health coverage.

Strengthening the Health Care System

The Commission recognizes that universal health care coverage can only be as sound as the health care system itself. Coverage that buys unnecessary or inappropriate care, that pays for poor quality, that fails to promote efficient delivery, or that shifts costs from some purchasers to others, wastes private and public dollars that could be used elsewhere.

The Commission disagrees strongly with the view that we cannot extend coverage to the uninsured until we control health care costs and reform the health care system.

The Commission believes, on the contrary, that expanding access to quality care and containing costs through increased efficiency are equally urgent and fundamentally intertwined goals. Ultimate success in reaching either goal can be achieved only through an integrated strategy of system reform. The Commission's recommended strategy has six parts..

1. The Commission believes that the nation needs a national system of quality assurance aimed at defining appropriate or necessary services and ensuring that patients receive these services.

The Commission recommends that national practice guidelines and standards of care be developed and implemented; that a uniform data system on all health care services, regardless of payment source or setting, be developed and implemented to support research on treatment outcomes and assessment of provider performance; that new methods of quality assessment and assurance be developed and tested; and that local organizations be developed and held accountable for effective quality assurance.

It is also imperative that we find a better way to deal with the problem of malpractice. Because there is, at present, insufficient evidence to support specific reforms, *the Commission recommends that the Physician Payment Review Commission and congressional committees study and explore the issue of malpractice and propose legislative remedies.*

The Commission believes that universal coverage should be designed in a way that promotes efficiency in service use and delivery of care. Several of its recommendations pursue this goal.

2. *The Commission recommends a minimum benefit package that, except for preventive services, includes significant consumer cost sharing (subject to ability to pay and an out-of-pocket maximum), so that consumers recognize and are sensitive to costs as they consume services.*

3. The Commission recognizes the efforts of employers and their private insurers to manage their health care expenses by encouraging appropriate use of services and negotiating appropriate payment rates with providers. *Accordingly, its recommendations include managed care as an appropriate means of service delivery for employers as well as the federal government. Insurers offering managed care to large employers would be required to extend that option to small employers as well.* The Commission's recommendations for insurance reform, if implemented, would further encourage managed care and other cost management innovations because insurers could no longer profit simply by avoiding the "poor" risks. Competition would have to be based on efficient service and health care expenditures management.

4. *The Commission recommends also that the newly established federal program adopt and extend Medicare's increasingly effective payment mechanisms.* Initially for hospitals and more recently for physicians, Medicare's payment rules have been refined to reward providers for delivering services efficiently. Applying these rules in the new federal program would extend their scope for publicly financed patients as well as provide a model for private insurers seeking new ways to control their costs.

5. The Commission recognizes that universal coverage in an efficient health care system is necessary but not sufficient to ensure all persons access to the care they need. People in isolated rural areas and inner cities, and particular segments of the population—minorities and the poor, pregnant teenagers, the physically or mentally disabled—would still face difficulties finding and getting the care they need.

The Commission recommends that expanded public coverage reinforce but not replace primary care delivery systems that are subsidized to serve these populations. It also recommends federal support to promote and extend systems that provide and coordinate a broad array of *social and health services. Moreover, it recommends provider payment methods and other mechanisms to ensure the general availability of health providers adequate to serve these most vulnerable citizens.*

6. The Commission's commitment to universal coverage in an efficient and effective health care system goes beyond ensuring access to treatment. Preventing the *need* for treatment ensures Americans the most secure and productive lives, and uses the nation's resources most efficiently.

The Commission therefore recommends federal support for programs of health promotion, disease prevention, risk reduction, and health education toward the reduction of excess morbidity and mortality, and toward the increase of healthy lifestyles.

Beneficiaries and Costs of the Commission's Health Care Recommendations

Building universal coverage in the way the Commission recommends would extend coverage to almost 32 million Americans under 65 who are now uninsured. It would also ensure adequate health insurance coverage for the 20 million under 65 who have some insurance, but are still exposed to catastrophic costs if major illness strikes. All Americans would be guaranteed affordable protection that ensures access to care when they need it.

> ***"I think these are the two words that [characterize what's going on in our country in health care]. The first one is 'wrong.' And the second one is 'stupid'. . . . [People] say South African apartheid [is] . . . wrong. . . . It's immoral. . . . The kind of suffering we have heard about here today is just wrong. . . . On the stupid side, we have already heard about the death, the suffering, the expense, the loss of productivity."***
>
> ***—Luanne Nyberg, director, Childrens' Defense Fund–Minnesota***

The Commission's strategy for ensuring adequate access to health care for everyone is achievable for less than 2 percent more than the nation spends for health care under current law. If the recommendations were implemented in 1990, the projected increase in total health care expenditures would amount to $12 billion, raising total current health care expenditures from $647 billion to $659 billion in 1990. (All cost estimates are for 1990.)

Table 1 Impact of Commission Plan on Health Care Spending, by Source

(In Billions, 1990)

Federal spending		$24.0
State and local spending		(7.4)
Employer spending (after taxes)		14.7
Employers who now insure	(12.8)	
Employers who do not now insure	27.5	
Household expenditures		(19.3)
Net new spending		$12.0

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model.

Not all sectors of society would be required to pay more, however (see Table 1). Employers who now offer health insurance to workers and their dependents are projected to save almost $13 billion because they would no longer bear the cost shift by insuring (as dependents) individuals who work for other firms or by paying for uncompensated care. Individuals and families are projected to save over $19 billion, as employers and government share their insurance and health care costs. State and local governments are projected to save more than $7 billion in payments now made for the uninsured, over and above Medicaid. Because states' contributions to expenditures under the recommendations would be limited in real terms to their current Medicaid contribution, they would also get some relief from the growing burden of financing care for the medically indigent.

Those employers who do not now provide health insurance for their workers and the federal government would share the new costs. Newly insuring employers would face a total of about $27.5 billion in increased payroll costs, less than 4 percent of payroll after taxes, on average. For a single employer, the increase could not exceed a specified percentage of payroll. This is because the Commission's recommendation allowing employers to choose a public health insurance program would effectively cap an employer's risk. The new federal costs of guaranteeing universal coverage would be $24 billion—to support adequate coverage for nonworkers and affordable coverage for workers and employers.

Some say we cannot afford universal coverage. The Commission believes that a decision *not* to make this investment would cost the country incomparably more: the disintegration of our health care system and the waste of our most precious resource, the health and human potential of our people.

Improving Protection for People 65 and Over

The above recommendations apply primarily to Americans under age 65. Nearly all elderly Americans receive their basic health insurance protection from Medicare. Nonetheless, gaps in Medicare protection expose the elderly to considerable financial risk. To address these gaps, the Commission recommends three actions, consistent with recommendations for younger Americans.

1. The Commission is concerned about protecting the elderly against excessive financial burdens in obtaining health coverage or health care. *The Commission therefore recommends that Medicare, or the public plan that replaces Medicaid at the federal level, provide assistance with the Medicare premium, deductibles, and cost sharing to all elderly people with incomes below 200 percent of poverty and undertake strong outreach efforts to ensure participation.*

2. Consistent with the insurance benefits provided to the under-65 population, *the Commission recommends that Medicare be expanded to provide selected preventive services. Preventive services to be added include mammography and colorectal and prostate screening services.* As with the under-65 population, other preventive services should be added when they are determined to be effective relative to costs.

3. Private insurance (usually termed Medigap) supplements Medicare for four out of five nonpoor elderly people. However, continued congressional oversight has documented that the Medigap market has historically been subject to considerable abuse and inadequacy.

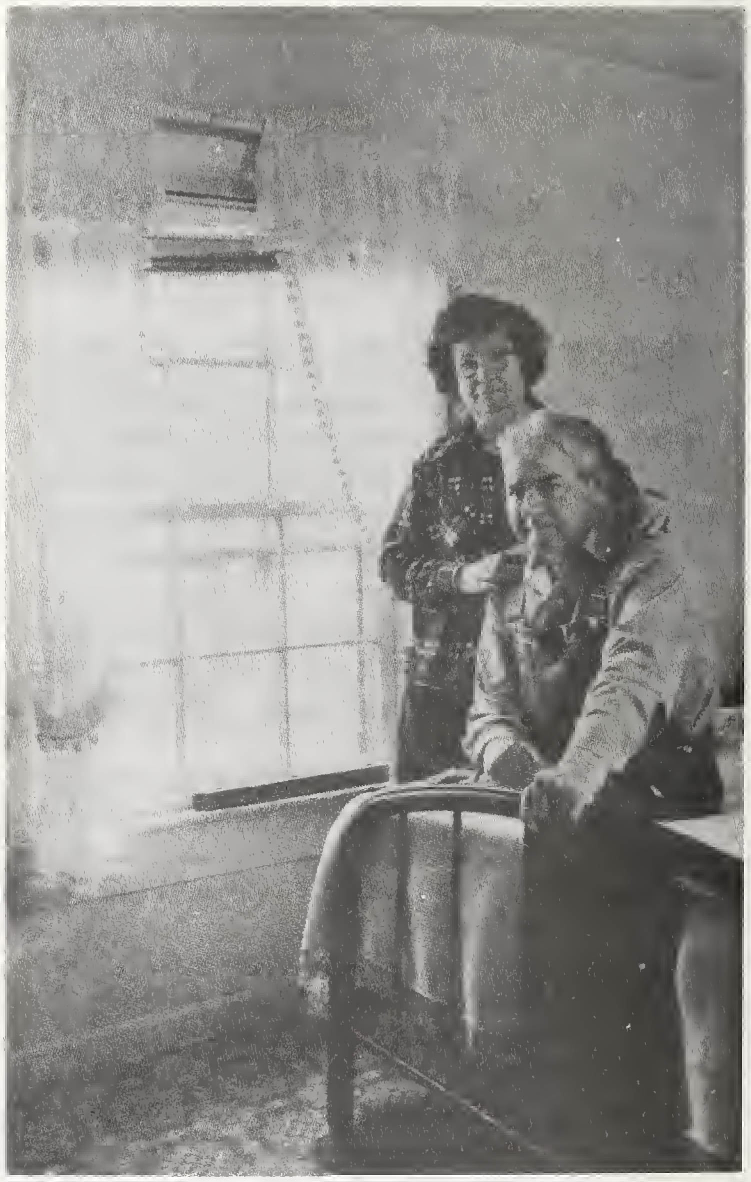
The Commission recommends federal action to ensure the nonpoor elderly access to adequate coverage through insurance reforms that are generally consistent with reforms the Commission recommends for other health insurance plans. Recommended action includes support for state or local counseling efforts and legislation to extend federal Medigap standards. Proposed standards would ensure policies of adequate value; allow consumers to compare policies and prices; and prevent sales abuses, duplication of coverage, and discrimination on the basis of health status.

These recommendations would, in combination, benefit 30 million Americans over the age of 65 at a total new federal cost of $2.8 billion.

WHY DO WE NEED LONG-TERM CARE REFORM?

Between 9 million and 11 million Americans of all ages are chronically disabled, dependent on others for help in the basic tasks of daily living that we call long-term care. As many as 4 million people are so severely disabled they cannot survive without substantial help from others. Millions more know the physical, emotional, and financial burdens of caring for relatives of friends who need such care—a mother with Alzheimer's disease, a child with cerebral palsy, a husband paralyzed from an automobile accident.

Yet in contrast to health care—for which most Americans have insurance, even if inadequate—there is almost no public or private insurance for in-home or nursing home care. Public support, primarily through the welfare-based Medicaid program, comes only after people have exhausted their own resources. Consequently, most Americans face the risk of impoverishment should they need long-term care.



EARL DOTTER

Without adequate public or private insurance, Americans who need long-term care are at risk of impoverishment.

At more than $2,500 a month, on average, the cost for even a short stay in a nursing home exceeds most Americans' incomes. At a national average cost exceeding $60 per visit, extensive home care is not far behind. Families exhaust themselves and their resources to provide care at home; long stays in a nursing home consume the savings of a lifetime. As the population ages and technology extends life for young and old disabled Americans alike, these burdens will only increase.

Who Needs Long-Term Care?

Two-thirds of the long-term care population are elderly; the rest are under 65.

The vast majority of people of all ages who need long-term care live in the community (see Figure 4). More than 5 million disabled elderly and over 3 million disabled younger people live at home (or in nonnursing residences). Nearly 2 million people live in nursing homes—1.5 million elderly and 0.2 million people under 65.

During their lifetimes, 36 percent to 45 percent of persons reaching age 65 in 1990 are expected to spend time in a nursing home before they die. A minority of 65-year-olds (about one in five) can expect to receive a year or more of nursing home care. But many nursing home users do not end their days in nursing homes after long stays. Between 26 percent and 45 percent of nursing home stays last fewer than three months, and half these "short stayers" are able to return to their homes.

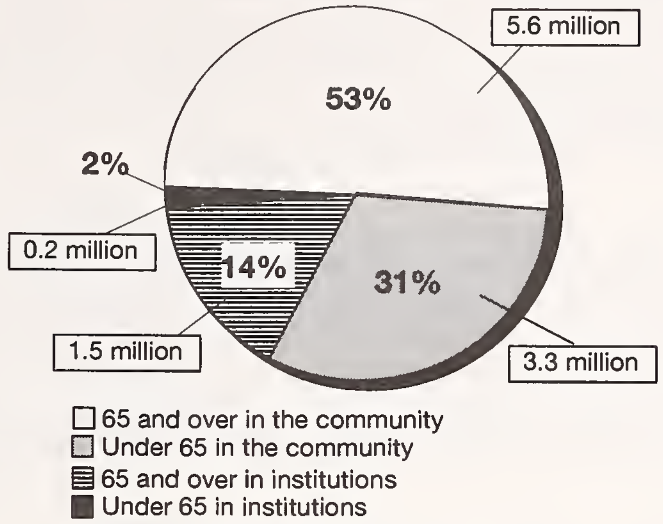
How People Get and Pay for Care

In 1988, the nation spent $53 billion on long-term care. Only 18 percent of these expenditures went to home care—despite that fact that four out of five disabled and almost three out of five severely disabled live at home. Most home care is provided by relatives and friends. And when people do buy home care, they get little help from public programs.

Public spending on nursing home care, by contrast, is substantial. Almost all of the private share is paid for, without the benefit of insurance, by the individuals and families who need the care. Public support for nursing home care is largely available only *after* people experience financial catastrophe. Consequently, most people who need nursing home care face enormous financial risk.

Caring for People at Home—Almost three-quarters of severely disabled elderly—and two-thirds of the most severely disabled elderly—in 1989 relied solely on family members or other unpaid help.

Figure 4 Residence of People Needing Long-Term Care



SOURCE: Lewin/ICF estimates using the Brookings/ICF Long-Term Care Financing Model.

More than 7 million spouses, adult children, other relatives, friends, and neighbors provided unpaid assistance to disabled elderly in 1984. Most of these caregivers are women. Four out of five caregivers average four hours a day, seven days a week. Many caregivers who make this extraordinary effort are vulnerable themselves. One-third are older people, have incomes below or near the poverty level, or are in poor health. More than one in 10 of all caregivers report leaving their jobs to provide care.

That families devote such effort to caring for disabled relatives is moving testimony to the strength of the human spirit. But the scale of their sacrifice suggests there may be objective barriers to purchasing help. For the minority who purchase long-term care services in the home, costs can be substantial. The most severely disabled spent an estimated $439 per month in 1982. And even people willing to pay face difficulty in finding the services they need and doubts about the quality of those services if they find them.

In 1988, federal and state governments spent about $7 billion on in-home services—about 37 percent through Medicare, 47 percent through Medicaid, and 16 percent through federal grant or state-funded programs. The programs differ in significant ways, but all are limited in their capacity to finance long-term care.

Eligibility for Medicare is limited to people who are unable to leave their homes (homebound) *and* who require skilled or professional service. Most people who need long-term care do not need skilled services, so Medicare is of little help. And few states rely on Medicaid to provide substantial long-term care to disabled people living at home. As with other Medicaid benefits, states control service and spending by limiting amount, duration, and scope of services; payment rates for providers; and eligibility. And the special waiver programs serve very few.

Two other major federal programs—the Social Services Block Grant program under Title XX of the Social Security Act and the Older Americans Act—do not carry stringent restrictions on eligibility, but provide only limited funding for in-home and community-based care. They are fixed-dollar allotments that states can use for many purposes besides long-term care.

A few states are investing substantial resources of their own in designing innovative in-home and community services programs. These initiatives provide models for broader coverage of care for disabled people at home. They are, however, the exception rather than the norm in the nation's effort to provide home and community-based care. Unless frail elderly and disabled Americans need skilled care and qualify for Medicare, or are poor *and* in a generous state, they must depend on their own resources and on relatives and friends to provide care.

Nursing Home Care—Despite the enormous efforts of disabled persons and their families to manage at home, nursing home care sometimes becomes inevitable. At this point, they face both emotional and financial devastation. Among elderly people with at least $3,000 in out-of-pocket spending annually, 83 percent of that spending goes for nursing home care. This fact reflects not only the absence until recently of private long-term care insurance (described below), but also the limits to public programs.

Medicare covers nursing home care only as a limited extension of its health care coverage. It does not cover the extended personal care that is the bulk of nursing home service.

Medicaid, on the other hand, provides almost 90 percent of the public financing for nursing home care and more than 40 percent of all nursing home revenues. But people receive Medicaid nursing home benefits only if they are, or have become, virtually destitute. In addition, Medicaid payment rates are so low in many areas that Medicaid patients—particularly those needing extensive care—may have problems finding care at all.

The Emergence of Private Long-Term Care Insurance

Private insurance to protect against financial losses from long-term care has only recently become available. Private insurers historically have been reluctant to offer such policies since it is so hard to predict the number of policyholders who will make claims and the cost of the services they will use. Although general health insurance entails similar risks, they are greater with long-term care. Services are harder to define, and there may be no need for care until decades after the policy is purchased.

Insurers have nevertheless begun to offer long-term care policies, and their availability has grown rapidly. The number of policies sold since 1987 has more than doubled. This does not mean that insurers no longer face risks, but that they have designed and marketed policies to limit their financial liability, thereby protecting their solvency.

Protection for insurers limits benefits to consumers. Insurers do not sell policies to people who are already disabled. Policies that provide some coverage may still leave consumers at risk of substantial expense when they need care.

Creativity and competition among insurers, along with regulatory requirements, have expanded benefits policies offer. But even in most improved policies, benefit levels do not keep pace with increases in service costs. Insurers can raise premiums or cancel policies, even after policyholders have paid substantial premiums.

And decent protection is expensive. The Health Insurance Association of America reports that for a 65-year-old, a relatively comprehensive policy costs about $1,400 in 1990; for a 79-year-old, the price is $4,000.

Some argue that more and more elderly will purchase long-term care policies, reducing the need for government protection. The fact is, only about 3 percent to 5 percent of the elderly currently own long-term care insurance. And for many elderly, the financial burden of these policies is patently prohibitive. Only about 6 percent of today's elderly could purchase the relatively comprehensive long-term care policy for as little as 5 percent of their annual income.

The emergence of job-based long-term care insurance, combined with anticipated increases in the elderly's income, makes some observers optimistic that private insurance will fill a considerable part of the need by the year 2020. But even if private insurance protection grows substantially, critical questions will remain:

- How to protect the currently disabled population as private insurance expands,
- How to ensure that the privately insured receive adequate protection and value for the dollar, and
- How to protect the population that private insurance will inevitably leave out.

Prospects for the Future

Growth in the numbers of people likely to need long-term care makes improvements in the nation's financing of this care imperative for the well-being of all Americans. If disability rates remain what they are today, the number of elderly persons needing help with basic tasks is expected to double between 1990 and 2030—increasing from about 7 million to almost 14 million. The number of elderly requiring nursing home care will more than triple—rising from about 1.5 million to over 5 million (see Figure 5). And the use of high-technology and new medical breakthroughs may continue to extend the lives of disabled people of all ages.

It is highly unlikely that service availability will keep up with these growing needs. Demographic trends predict that fewer family members will be available to care for their disabled relatives. The private marketplace seems unable to develop an adequate home care delivery system even for those who can pay. The two major public programs—Medicare and Medicaid—have structural limitations that prevent them from meeting the projected need.

Without a change in public policy, more and more Americans will have difficulty getting the care they need in nursing homes as well as at home.

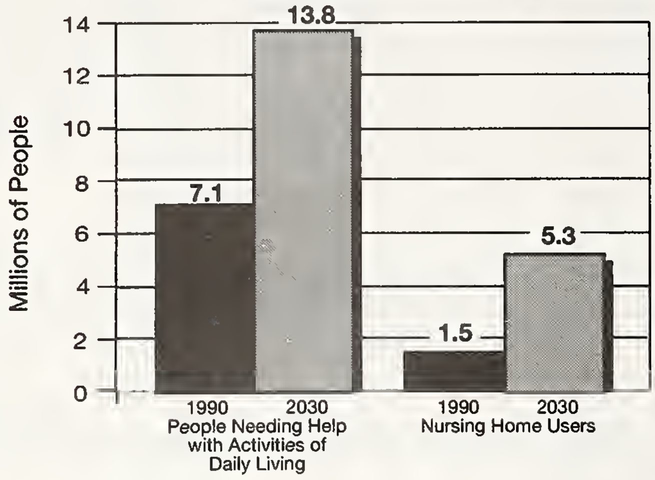
BLUEPRINT FOR LONG-TERM CARE REFORM

The Commission concludes that federal action is essential to change the nation's fundamentally flawed approach to long-term care financing, and that such action should follow an insurance strategy (public or private or both). The Commission rejects the alternative of encouraging private savings to cover long-term care costs. Depending on private savings concentrates the financial burden of severe impairment—an expensive and largely unpredictable event—

ROMAN SAPECK/MOUNT CARMEL HEALTH

By 2030, the number of elderly people requiring nursing home care will more than triple.

Figure 5 Number of Elderly Needing Long-Term Care, 1990 and 2030



*Projected

SOURCE: For 1990, Lewin/ICF estimates using the Brookings/ICF Long-Term Care Financing Model; for 2030, Shelia Zedlewski, et al., *The Needs of the Elderly in the 21st Century* (Washington, D.C.: The Urban Institute, 1990).

on the unlucky few who experience it, rather than spreading it among the many who are at risk of impairment. Failure to reform the system on an insurance basis is not only to abandon today's elderly and disabled but also to condemn growing numbers of Americans to inadequate access to care in the future.

To prevent this outcome, the Commission unanimously adopted the following goal:

> The Pepper Commission is committed to the development of recommendations for public policies that give Americans of all ages access to coverage that provides them necessary long-term care and adequate financial protection; that will assure quality care and choice of setting and will control costs; that will provide the financing required to assure access; and that will support research to prevent the need for long-term care.

The Commission explored a range of possible strategies to achieve this objective. One strategy would be to enhance government protection for the low-income population and promote adequate private insurance protection for the better-off. The Commission believes, however, that to build such a two-tiered system would be to repeat the nation's unfortunate experience in health care. Too many people would continue to face impoverishment or find themselves dependent on a welfare-based system, a system unable to ensure access to quality care.

Another strategy would be to develop a comprehensive public insurance program for all long-term care services. The Commission believes that public or social insurance has considerable merit in guaranteeing adequate protection to all Americans, regardless of income. However, the Commission is concerned that applying this strategy to all nursing home care, as well as to home care, has disadvantages. Namely, it would require substantial public resources and would provide unlimited protection of assets for people who could well afford to protect themselves through private insurance.

To target public resources most effectively, guarantee Americans of all incomes adequate protection, and achieve an appropriate balance between public and private insurance, the Commission recommends a limited social insurance approach. The Commission believes that federal social insurance for home- and community-based care is essential to ensure the development of an adequate and efficient delivery system for these services and that priority in the use of public resources should go to disabled people at home or able to come home after short nursing home stays. People in nursing homes should be guaranteed an ample floor of protection, ensuring that no one—regardless of length of stay in the nursing home—will become impoverished. All but the poorest should contribute to the costs of their care.

Building a Long-Term Care System

Based on these principles, the Commission recommends developing an integrated public program that would meet the diverse needs of severely disabled people and support private insurance for those seeking broader protection. The blueprint has nine parts.

1. *The Commission recommends social insurance for home and community-based care and for the first three months of nursing home care, for all Americans, regardless of income.* Individuals would be required to contribute to the costs of care, with subsidies for people with low incomes. This protection would sustain resources and standard of living when people need long-term care, just as Medicare or private health insurance does when they need physician or hospital services.

2. *For people with long nursing home stays, few of whom return home, the Commission recommends a floor of protection against impoverishment—protection of $30,000 in assets (excluding homes) for individuals and $60,000 for couples—and protection of income for spouses, home maintenance, and a decent allowance for personal needs.* Protected assets are approximately equal to the life savings of three out of five elderly people. People whose assets exceed the floor would not receive benefits until their unprotected assets were depleted. Income above protected amounts would be applied toward the cost of nursing home care.

3. Recognizing that many people will want additional protection for assets and income above levels protected for long stays—as well as for cost sharing obligations associated with other benefits—*the Commission recommends measures to promote private long-term care insurance, subject to federal and state oversight.* Promotion would involve clarifying the tax code to give long-term care insurance the same preferential tax treatment health insurance now receives. Oversight would entail standards for insurance policies, consumer counseling to evaluate policies, and penalties on insurers for failure to comply.

4. The Commission believes that all severely disabled persons—regardless of age, underlying disease or disabling condition—be eligible for public benefits, at home or in a nursing home. To qualify for long-term care benefits at home or in a nursing home, *the Commission recommends that individuals meet at least one of the three following disability criteria:* (a) *need hands-on or supervisory assistance with three out of five activities of daily living;* (b) *need constant supervision because of cognitive impairment that impedes ability to function;* or (c) *need constant supervision because of behaviors that are dangerous, disruptive, or difficult to manage.* Individuals assessed as severely disabled would be directed to a case manager for help in obtaining home care or assisted in obtaining a nursing home placement.

5. To ensure that home care services support but do not replace family caregiving and are managed in a fiscally responsible manner, *the Commission recommends relying on case managers to develop and oversee individual care plans.* Within a federally determined budget, case managers would be free to allocate a broad array of services, tailored to people's needs and preferences. *The Commission recommends that benefits include personal care, homemaker/chore services, shopping and other support services, day care (for disabled adults and children), respite services, and training for family caregivers, as well as skilled nursing and rehabilitative care.*

6. Under the recommended plan, both federal and state governments would be responsible for financing and administering public benefits. *The Commission recommends that the social insurance portions of the public program be fully financed by the federal government. The federal government and the states would share financial responsibility for long nursing home stays.*

In administering benefits, the Commission seeks a balance between ensuring equal and adequate protection for all severely disabled, regardless of the state in which they live, and allowing flexibility to tailor services to diverse populations and communities. *The Commission therefore recommends that the federal government contract with the states to administer the plan. The federal government would be responsible for setting guidelines and adequate standards for this administration.* The federal government would certify assessment agencies and develop standardized assessment criteria, set guidelines for certifying case managers and establish their budgets (described below), set guidelines for quality assurance and appeals procedures, and determine provider payment rates. Within federal guidelines, states would develop and certify case management and delivery systems, certify providers, establish review and appeals procedures, and enforce quality standards.

7. The Commission recognizes that financial support for long-term care can be effective only if it promotes and ensures quality of care. Furthermore, to be sustainable over the long term, a program must be designed in a way that controls expenditures. The recommended plan therefore includes several measures to ensure quality and control costs.

The recently enacted nursing home requirements would apply to the recommended nursing home coverage, and standards would be developed for care in the home.

Alongside these standards, the Commission believes that case management, an integral part of its recommended home care benefits, plays a critical role in ensuring quality and managing costs. *The Commission recommends that case managers allocate services and monitor service delivery within a budget set by the federal government.* This approach would ensure fiscal constraint and the capacity to tailor services to individual needs and preferences.

The Commission further recommends that the federal government establish provider payment mechanisms and determine appropriate rates. Prospective payment systems can be used to ensure access to quality care, efficiently delivered, and to control spending for care.

8. The Commission recognizes both the urgent needs of the currently disabled and their families for public support and the time it will take to build a long-term care system. *The Commission therefore recommends that the plan be put into place a step at a time over a four-year period.* The program would begin with limited home care benefits to relieve the burdens on family caregivers. Benefits would be expanded over the next four years, until full coverage is reached. Nursing home coverage would begin in year two. Payment rates would be increased gradually over the subsequent two years to ensure adequate supply and quality of service.

9. In establishing a long-term care system, the Commission believes it essential to assess the effectiveness of treatment, delivery, and management of services, and to explore means to prevent the need for long-term care services.

The Commission recommends that the federal government move aggressively to contain costs and mitigate human suffering by funding a research and development program aimed at preventing, delaying, and dealing with long-term illnesses and disabilities.

Research should encompass special problems of minorities; the development of outcome measures and practice guidelines; and evaluation and innovation in assessment, quality assurance, and service delivery mechanisms, especially in care at home.

Beneficiaries and Costs of the Commission's Long-Term Care Recommendations

The Commission's recommendations provide a blueprint for developing a national long-term care system. Home and community-based care would be available and affordable. People who need nursing home care for short periods would have their resources preserved intact to return home. And no one would have to fear impoverishment if they end their lives in a nursing home. People would contribute to the costs of care for all services subject to their ability to pay. They would also have broader access to private insurance to cover these costs. All Americans would benefit from the new public program, for it provides everyone peace of mind in the face of long-term care needs.

But long-term care is expensive—averaging more than $2,500 per month for nursing home care and over $60 a visit for in-home support. We cannot build a system that ensures adequate service to people who need it merely by shifting around the dollars we spend today. New expenditures are required.

If the program were in place today, it would serve 4.4 million people at a net new federal cost of $42.8 billion—$24 billion for care at home and $18.8 billion for nursing home care. About three-quarters of total spending would go to the elderly and about a quarter to people under 65 (see Table 2).

For the severely disabled elderly, new federal spending would be split almost evenly between home care and nursing home care ($15 billion and $16.8 billion, respectively). For nursing home care, the floor of protection against impoverishment would cost about $11.3 billion; broader protection for short stays would cost another $5.5 billion. For younger severely disabled, most of whom live in the community, almost all new spending ($9 billion out of a total $11 billion) would go to home and community-based care.

The new program would serve some 2 million severely disabled elderly people at home every year, doubling the number who now receive paid support. For the 1 million people who would have purchased their own care in the absence of the public program, out-of-pocket savings in 1990 are estimated to be $900 million—about $1,000 per user.

Because more people would have access to better nursing home care under the Commission's program, nursing home use is also expected to increase. Under the recommended program, about 1.2 million people a year are expected to enter nursing homes. All would receive some public support. People who would have used the nursing home at their own expense or spent down to Medicaid in the absence of the new program would save $6.9 billion in out-of-pocket expenses, or about $3,000 per user. Under the recommended new public program, all 1.2 million nursing home entrants would receive coverage for the first three months of nursing home care. For almost half of all entrants, or 528,000 people, the three-month social insurance bene-

Table 2 **Beneficiaries and Net Federal Costs of Commission Long-Term Care Recommendations, by Age Group and Type of Service**

	Home Care	Nursing Home Care	Total
Total Beneficiaries (In Millions)			
Elderly	2.0	1.2	3.2
Nonelderly	1.0	.2	1.2
Total	3.0	1.4	4.4
New Federal Costs (In Billions, 1990)			
Elderly	$15.0	$16.8	$31.8
Nonelderly	9.0	2.0	11.0
Total	$24.0	$18.8	$42.8

SOURCE: For elderly, Lewin/ICF estimates using the Brookings/ICF Long-Term Care Financing Model; for nonelderly, Commission staff estimates.

fit would cover their entire nursing home stay. The majority of "long stayers" (425,000 entrants) would have their assets fully protected. A minority (79,000 people) would acquire asset protection during their stay.

Although people would no longer be expected to devote all their resources to long-term care before they could receive public support, all but the poorest would be expected to contribute to the costs of care. Under the Commission's recommendations, individuals could be responsible for cost sharing equivalent to as much as $12 per home care visit or—for short stays—$15 per nursing home day. For long nursing home stays, they would contribute assets and income above protected levels. The Commission recommendations would facilitate the purchase of private insurance to cover these expenses, through both assistance and oversight to ensure adequate policies and favorable tax treatment for policies purchased.

This count of people and dollars significantly understates the benefits long-term care coverage would bring. Families of the severely disabled would receive badly needed help in caring for their impaired loved ones. Employed caregivers, or caregivers who could be employed, would be better able to balance responsibilities at home and on the job. Employers would reap the benefits of a more secure and productive work force.

Finally, and perhaps most important, all Americans would benefit from the security of knowing that if the need for long-term care should arise—for themselves, their parents, or their children—they would not be left to cope on their own. The nation would have a system to which everyone in need could turn for help.

REVENUES TO FINANCE COMMISSION RECOMMENDATIONS

The estimated new federal cost of the Commission's recommendations—health care plus long-term care for people of all ages—would be about $69.6 billion if fully implemented in 1990. Although some of these funds could be raised from reductions elsewhere in the federal budget, the Commission recognizes that new revenues will be necessary. To finance the new costs of the program entirely through new taxes in 1990 would require about $430, on average, from each nonpoor American adult. Various tax packages would spread the burden in different ways.

The Commission recommends that three criteria guide the selection of options for raising these revenues:

- *Taxes should be progressive, requiring a higher contribution from those most able to bear increased tax burdens.*
- *Revenues should be able to grow fast enough to keep up with benefit growth.*
- *Contributions should come from people of all ages.*

A CALL FOR ACTION

Congress called upon the Commission to recommend legislation to ensure all Americans coverage for health and long-term care. With this report, the Commission fulfills its task. Now the Commission calls for action from the Congress and the President to turn its recommendations into law.

The Commission's investigations leave no doubt that Americans' fears about their health care system are well founded. Without action, people cannot rely on coverage they can afford or care when they need it.

The Commission not only documents the problems our citizens face; it puts forward workable solutions. In health care, we can build upon and strengthen the coverage we now have. In long-term care, we can identify priorities and build the coverage we now lack. We can build carefully and deliberately, one step leading to the next.

Universal coverage in an effective, efficient system is within our reach. We must act now.

Chapter 1

Why Do We Need Health Care Reform?

Chapter 1

Why Do We Need Health Care Reform?

The American health care system is approaching a breaking point. Rising medical costs are increasing the numbers without health coverage and straining the system's capacity to provide care for those who cannot pay. The gap is widening between the majority of Americans, who can take advantage of the best medical services in the world, and the rest, who find it hard to get even basic care. As the gap increases, the weight of financing care for those without adequate coverage is undermining the stability of our health institutions. Even for the majority, the explosive growth in health care costs is steadily eroding the private insurance system—the bulwark they count on as their defense against financial risk in the event of serious illness.

Our two basic systems for providing health coverage for nonelderly Americans—job-based insurance and public health care coverage by Medicaid and other state-based programs—share the blame. Cost-motivated benefit cutbacks by large employers and the disintegration of the health insurance market facing small employers jeopardize coverage most of us count on through the workplace. Public programs targeted to the poor fail to take up the slack..

The Commission examined the characteristics of the uninsured and reasons for the recent growth in the uninsured population. It identified trends in the private insurance market that are making coverage harder to purchase, along with reasons why the Medicaid safety net is failing to protect so many low-income Americans. The Commission looked, too, at the consequences of being without insurance—needless sickness and disability because of care delayed or denied. It reviewed our current system of providing care to those who cannot pay through public subsidies and hidden taxes on private payers. It also looked at the pressures of rising costs and growing needs that are eroding this system. Finally, the Commission considered nonfinancial barriers to medical care: the shortages of doctors and services in our rural areas and inner cities, and the special needs of such populations as minorities, the physically and mentally handicapped, and the chronically ill.

EARL DOTTER

Although most Americans get health insurance through their jobs, three out of four uninsured people are workers or in workers' families.

WHO LACKS HEALTH INSURANCE PROTECTION?

In 1987, 31.5 million Americans under age 65—nearly 15 percent of the nonelderly population—were without health insurance (see Table 1-1).[1] About 28

Table 1-1 Nonelderly Uninsured Persons, by Age, Sex, and Race/Ethnicity, 1987

	Number of Uninsured Persons (in millions)	Percentage of All Uninsured	Uninsured as Percentage of Persons in Group
Age of individual:			
Less than 18	8.9	28.2	13.2
18–24	6.1	19.4	27.3
25–44	11.4	36.2	14.7
45–64	5.1	16.2	11.2
Sex of individual:			
Male	16.7	53.1	15.8
Female	14.8	46.9	13.8
Race/ethnicity:			
White	24.5	77.8	13.7
Non-white	7.0	22.2	20.3
Hispanic *	6.0	19.0	32.4
All nonelderly persons	31.5	100.0	14.8

* Hispanics are white and non-white.

SOURCE: Lewin/ICF analysis of the March 1988 Current Population Survey data.

percent of U.S. residents lacked health insurance for at least a month during the 28-month period ending May 1987.[2]

Anyone can become uninsured and the uninsured include people of all ages, incomes, and employment status. But the following characteristics of the uninsured population stand out.

The uninsured are disproportionately young. Nearly half are under 25 years of age, and more than a quarter are children under 18 (see Figure 1–1). Young adults aged 18 to 24 are the group most likely to be without protection; in 1987 more than a quarter of these young people lacked health insurance (see Figure 1–2). They are likely to be in entry-level jobs with no insurance and, working or not, are often too old to be picked up as dependents of a privately insured or Medicaid-eligible family member.

The uninsured are disproportionately poor or near-poor (see Table 1–2, Figure 1–3). About 30 percent are in families with incomes below the federal poverty level; just over 30 percent are in families with incomes between 100 percent and 200 percent of poverty.

Although disproportionately low income, however, the vast majority of the nonelderly uninsured, about 75 percent, are either workers or live in families of workers (see Table 1–3 and Figure 1–4). Five out of eight uninsured people work full time or are the dependents of full-time workers.

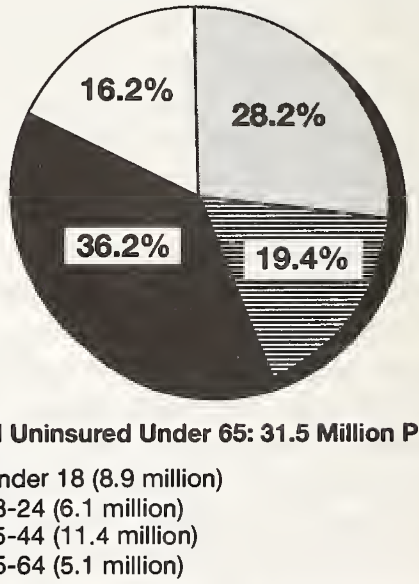
Growth in the Uninsured Population

There have always been Americans without health insurance, but the proportion of the population without insurance has grown during the last decade.[3] Current Population Survey (CPS) data indicate that the proportion of the nonelderly without insurance grew from 14.6 percent in 1979 to 17.5 percent in 1984, and stayed at that level at least through 1986 despite the economic recovery from the 1982 recession (see Figure 1–5).

The trend since 1986 is unclear because the CPS questions asking about insurance have been changed and appear to be finding fewer people without insurance. In 1988, for example, the CPS identified about 15 percent of the nonelderly population without insurance. This does not mean that the growth in the uninsured found in earlier surveys was not real. If the same improved counting methods could be applied to the entire period since 1979, the uninsured population would probably have been smaller in each year, but the upward trend would have been unlikely to change.

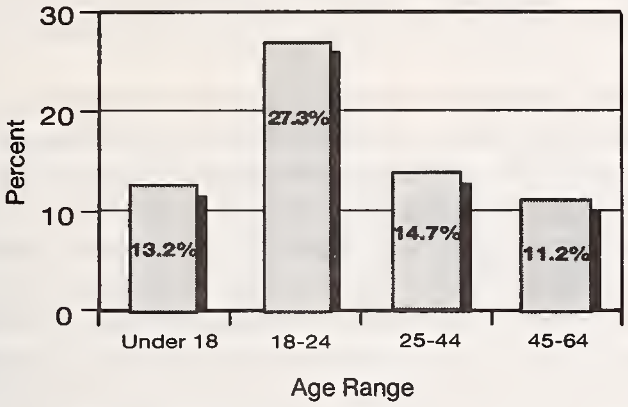
One factor contributing to the decline in coverage is a slight reduction in the proportion of workers covered through their own work—probably due to shifts

Figure 1-1 Distribution of Nonelderly Uninsured, by Age, 1987



SOURCE: Congressional Research Service analysis of Lewin/ICF estimates based on Current Population Survey data, March 1988.

Figure 1-2 Percentage of Nonelderly People Without Insurance, by Age, 1987



SOURCE: Lewin/ICF Inc., analysis of Current Population Survey data, March 1988.

in employment from industries that are likely to provide coverage (such as heavy manufacturing) to those that are not (such as parts of the service sector and retail trade).

Another is the lower proportion of the population getting coverage through another family member's employment. Part of this reduction is simply a consequence of the decline in coverage of primary workers. But part is because employers have reduced their contributions toward coverage of dependents. Ten years ago two-fifths of employers paid for dependent coverage in full; today the proportion has dropped to one-third. As employees are asked to pay more for dependent coverage increasing numbers can be expected to drop it, particularly low-wage workers with other pressing financial needs.

The changing nature of American families may also play a role. The proportion of households with older children and unrelated individuals has been growing, and insurance policies generally do not allow such persons to be covered under family policies.

Accompanying the decline in employer-based coverage has been a drop in coverage from non-employment-based sources, especially Medicaid. Although the absolute number of people in poverty was rising for at least the first half of the 1980s, the number receiving Medicaid has remained almost unchanged for a decade. Recent changes in Medicaid policy have expanded program enrollment, especially among pregnant women and young children. But preliminary data suggest that these expansions may be offset by dropping enrollment among other segments of the Medicaid population.

The Problem of Inadequate Protection

Many people assume that simply having insurance means adequate protection. This is a dangerous mistake. In addition to the 32 million Americans with no health coverage at all, millions are exposed to the risk of devastating financial losses or are unable to obtain needed care because their insurance protection is inadequate.

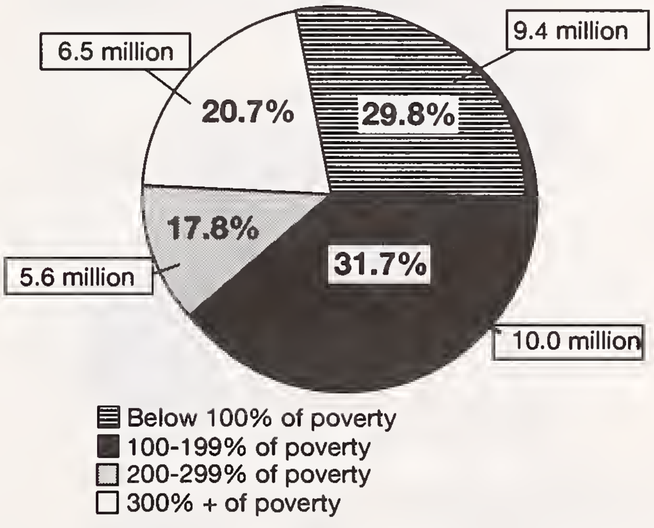
A commonly accepted measure of inadequate coverage is health insurance that leaves the person covered at risk of spending more than 10 percent of income on health care in the event of a costly illness. An estimated 13 percent of the under-65 population were underinsured by this definition in 1984—about 20 million people in 1987.[4, 5] The problem is most severe for people in nongroup plans—people who buy

Table 1-2 Family Income Distribution of Nonelderly Population Without Health Insurance, 1987

Annual Family Income as a Percent of Poverty	Number of Uninsured Persons (in millions)	Percentage of All Uninsured	Uninsured as Percentage of Persons in Group
0–100	9.4	29.8	32.1
101–200	10.0	31.7	27.4
201–300	5.6	17.8	14.1
300+	6.5	20.7	6.0
Total	31.5	100.0	14.8

SOURCE: Lewin/ICF analysis of the March 1988 Current Population Survey data.

Figure 1-3 Distribution of Nonelderly Uninsured, by Family Income as a Percentage of Poverty, 1987



SOURCE: Lewin/ICF analysis of Current Population Survey data, March 1988.

Table 1-3 Work Force Connections of the Uninsured, 1987

(In Millions)

States	Number Uninsured	Percent of Total
Employed persons	14.4	45.7
Full-time workers	11.7	37.1
Part-time workers	2.7	8.5
Nonworking dependents of workers	9.4	29.8
Dependents of full-time workers	7.9	25.1
Dependents of part-time workers	1.5	4.7
Uninsured with no connection to employment	7.7	24.5
Total uninsured	31.5	100.0

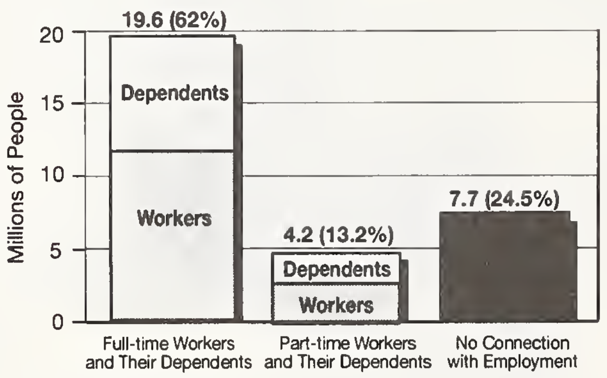
SOURCE: Lewin/ICF analysis of the March 1988 Current Population Survey data.

insurance on their own, rather than obtaining it through job-based or other groups. Just over half (52 percent) of these people were underinsured in 1984.[6]

Three major features of insurance plans determine out-of-pocket expenses for which an enrollee is at risk.[7]

First, a specific service may be excluded from a policy, leaving the enrollee liable for its full cost. According to a 1986 survey of all businesses conducted by the Small Business Administration, 17 percent of all firms exclude physician office visits from their health plans, 13 percent exclude outpatient prescriptions, and 18 percent exclude mental health services.[8] In addition to blanket exclusions, some policies exclude services from coverage if they are needed for a medical problem that was already being treated at the time the policy took effect (a "preexisting condition"). Nongroup plans are also likely to include exclusion waivers, which may temporarily or permanently exclude a specified medical condition from coverage.

Figure 1-4 Work Force Connections of the Uninsured and Their Dependents, 1987*

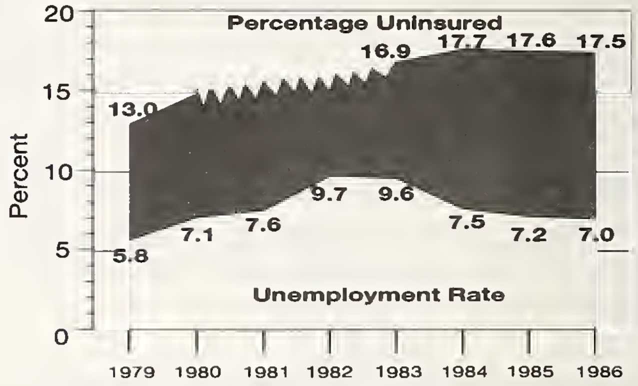


*Under 65 Population

SOURCE: Lewin/ICF analysis of Current Population Survey data, March 1988.

The second feature consists of payments required even for covered services. Enrollees are generally responsible for an initial payment for covered services—a deductible. After the deductible is paid, the plan may also require enrollees to pay a percentage of costs incurred for covered services, usually 20 percent. About 83 percent of plans offered by medium and large firms have an out-of-pocket cap that places a ceiling on the enrollee's annual liability for covered services. But some plans have no such limits on coinsurance payments, leaving enrollees at risk for unlimited health care expenses. Nongroup enrollees are more than twice as likely as group enrollees to have no out-of-pocket cap. In addition to deductible and copayment requirements, some plans reimburse the provider of services an amount less than the fee charged, leaving the enrollees liable for the balance.

Figure 1-5 Trends in the Uninsured Population and Unemployment Rates (In Percent)



*Unemployment is a percentage of the workforce; uninsured status, a percentage of the under 65 population.

SOURCE: For the uninsured, Congressional Research Service analysis of Current Population Survey data for selected years (data on the uninsured are unavailable for 1980, 1981, and 1982). For unemployment rate, U.S. Congress, House Committee on Ways and Means, Overview of Entitlement Programs: 1990 Green Book, 101st Cong., 2d Sess., 190, WMCP 100-293, 479.

The final feature determining out-of-pocket expenses is a lifetime maximum provision. Enrollees in plans with such a provision are held accountable for all expenses beyond the maximum. About 60 percent of all plans have no maximum lifetime benefit or a maximum of $1 million or more. But 11 percent of all plans have a maximum of only $250,000. Another 3 percent of plans set an even lower limit. These thresholds can readily be exceeded by very severe burns or trauma, extremely sick newborns, some types of organ transplants, and other expensive conditions. And about 2 percent of plans set maximum benefit limits per year or per illness instead of lifetime limits; these plans leave enrollees even more exposed to catastrophic loss.

Although this discussion focuses on the population under age 65, older Americans also face a problem of underinsurance. Medicare covers hospital stays and physician services, but it includes substantial premium and cost sharing requirements, with no limit on out-of-pocket expenses. These expenses, along with expenses on services Medicare does not cover, expose low-income elderly, in particular, to the risk of catastrophic costs. On average, elderly people with per capita income of $10,000 or less spent 14 percent on out-of-pocket costs in 1986, in contrast to 7 percent for elderly with per capita income above $10,000.[9]

Seventy percent of the elderly have private insurance to protect against Medicare's cost sharing requirements. Premiums for a typical policy can exceed $500 a year, however, and policies are often confusing to understand. The Medicaid program protects 8 percent of the elderly population against out-of-pocket expenses. But many low-income elderly lack Medicaid protection because income and resource tests limit eligibility. Twenty-two percent of elderly people rely solely on Medicare and are at risk of substantial financial burdens should they become sick.[10]

WHY IS PROTECTION LACKING?

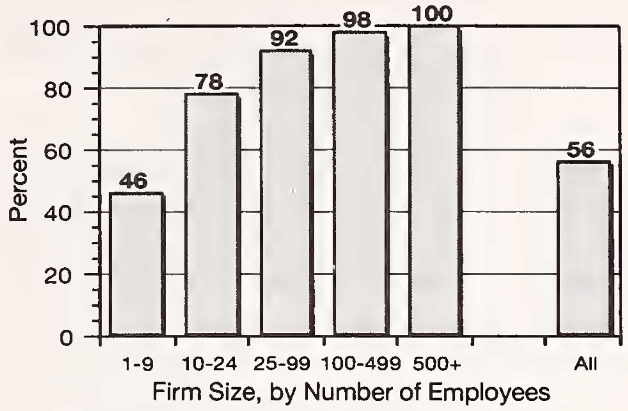
In the United States, most workers and their families obtain coverage through their jobs. Some of the poor obtain coverage through Medicaid. Both job-based and Medicaid coverage suffer from remediable defects that limit their reach.[11]

Problems in Employment-Related Coverage

Health insurance has become an integral part of employee compensation for most American workers and is almost universal among full-time employees in medium and larger private businesses (those with 100 or more employees) and state and local governments.[12] The very breadth of job-based health insurance makes it all the more shocking that three out of four Americans without insurance in 1987 were either themselves workers or lived in families of workers.

The likelihood that workers will obtain job-based coverage for themselves and their families varies according to two key factors: the size of the firm they work for and the nature of the business in which it is engaged.

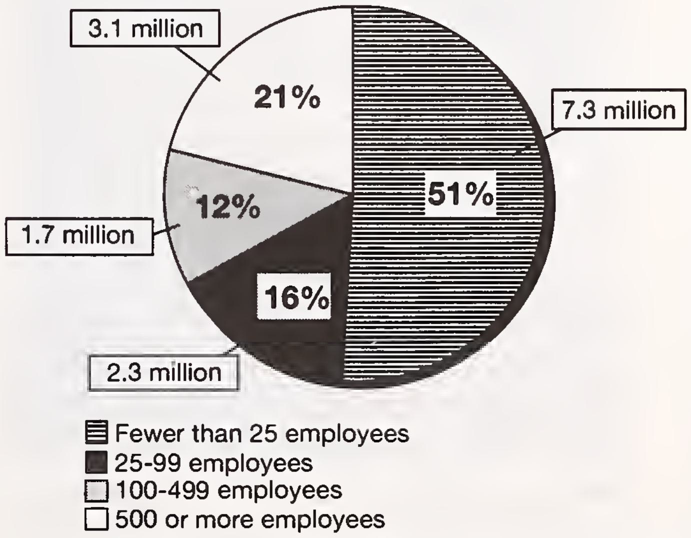
Figure 1-6 Percentage of Firms with Health Insurance Plans, by Firm Size, 1986



SOURCE: ICF Inc., analysis of health benefits database, Small Business Administration, Office of Advocacy, 1986.

Firm Size and Industry Differences—The smaller the firm, the less likely it is to provide health insurance coverage (see Figure 1-6). In 1987, just over half of all uninsured workers were in firms of fewer than 25 employees (see Figure 1-7). Almost one in four employees in such firms lacked coverage of any kind; more than two-thirds lacked coverage directly from their employers. In firms with 500 or more employees far smaller proportions of employees were without coverage (see Figure 1-8).

Figure 1-7 Uninsured Workers, by Firm Size, 1987*



* Distribution of uninsured workers and dependents by firm size is similar.
SOURCE: Lewin/ICF analysis of Current Population Survey data, March 1988.

Coverage is least likely in firms with fewer than 10 employees, which account for about 11 percent of the work force but represent three-quarters of the nation's businesses. Fewer than half the firms of this size were estimated to offer health insurance in 1986, compared to close to four out of five firms with 10 to 24 people, and over nine out of 10 larger firms.

The likelihood of being offered job-based health insurance also varies by industry. Industries whose workers were least likely to get coverage through their jobs in 1988 were agriculture, forestry and fisheries; personal services; entertainment and recreation services; and retail trade. About 70 percent of workers in these industries lacked coverage from their employers and over 20 percent lacked coverage from any source.[13]

What sets firms in these industries apart? First, they tend to be small; firm size and industry overlap. Second, they are more labor intensive, less profitable, and less stable than firms in other industries. Third, their employees are less likely to be unionized, more likely to be part-time or seasonal workers, and more likely to move often from job to job—factors that tend to deter employers from establishing health insurance plans.

In part, then, firm size and industry reflect other characteristics of a business that affect its willingness or ability to offer insurance. Firms with low profit margins may be reluctant to finance coverage. And those with an unskilled, low-wage work force may be able to recruit enough workers without having to offer health coverage or other fringe benefits. But firm size and industry type also directly influence whether a business can buy insurance at an affordable rate. Small employers, in particular, are at a serious disadvantage in purchasing coverage. In order to un-

NOREEN REBICH

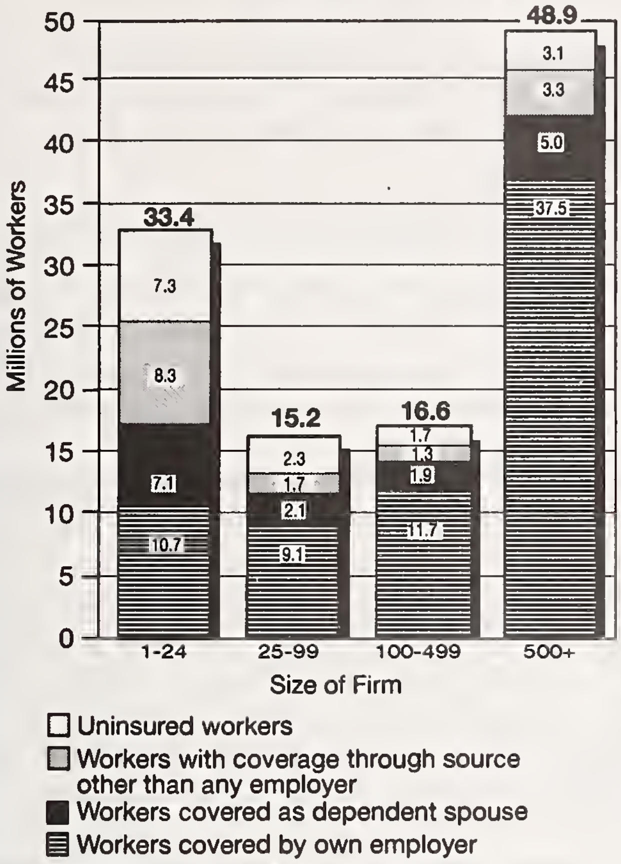
Nola and Kent Olson—self-employed contractors unable to afford insurance—face $61,000 in debt after an auto accident.

The lives of Nola and Kent Olson, a self-employed couple from Florence, Montana, changed dramatically after a car accident left Mrs. Olson a quadriplegic—and completely dependent on her husband. Only months before the accident, the Olsons cancelled the health insurance policy held through their contracting firm. It was too costly, and they had never used it. Ironically, the accident left the couple $61,000 in debt.

As sole caregiver, Mr. Olson can't leave his wife by herself. This has profoundly affected their business. They have had to hire additional employees, which reduces their slim profit margin. And cutting their own salaries to keep their business competitive has made their home situation even more difficult.

The Olsons are deeply concerned about the future. Mrs. Olson is uninsurable, so they must pay out-of-pocket for further health needs. "We manage now," Mrs. Olson told the Commission, "but I wonder what would happen if my condition worsened. We can't afford more help. I don't know how we could handle a problem requiring hospitalization. And what if something should happen to Kent? I don't know how we would manage."

Figure 1-8 Workers and Source of Health Insurance, by Firm Size, 1987



SOURCE: Lewin/ICF estimates from current population survey data, March 1988.

derstand why this is so, it is necessary to examine the evolution and current practices of the health insurance market.

The Small Group Health Insurance Market—The American private health insurance system has evolved over the course of this century.[14] In the 1930s the original Blue Cross and Blue Shield plans, along with similar plans developed by providers or consumers of care, offered insurance at fixed rates to all purchasers. (This practice is called community rating.) Since the care of low-risk individuals and groups costs less than the care of the higher-risk segments of the insured population, these fixed rates subsidized the higher-risk segments at the expense of the lower-risk segments.

When commercial insurance companies entered the market in the 1940s, they began to compete for large group customers by offering low-risk groups reduced rates. Low-cost groups demanded that the rates they paid for coverage be related to the costs incurred for their group alone. Commercial insurers obliged by adjusting a group's rates in the light of actual cost experience for that group (experience rating). Ultimately Blue Cross and Blue Shield were obliged to follow the lead of the commercial insurers and also offered some form of experience rating to large employers. Some large employers could even afford to self-insure—that is, to assume directly the financial risk for health care costs incurred by their employees. In the last decade the proportion of firms self-insuring has increased dramatically.

Smaller employers cannot be experience-rated, because small numbers render past experience a poor predictor of future costs. However, insurers have resorted to a variety of other means to sort out potentially high-risk groups from low-risk ones, as described below. Once one insurer in this highly competitive market began to adopt these practices, others had to follow suit: competition among insurers became competition for the best risks.

Small firms are rated by insurers according to the characteristics of the industry to which they belong. Different insurers use different criteria for classifying industries as ineligible for insurance or eligible only with restrictions. But among the characteristics considered are seasonal employment (for example, in hotels, restaurants, or contracting); high risk of occupational illness or hazard (in industries like mining, logging, or commercial fishing); and high failure rate (see Table 1-4).

Table 1-4 Examples of Industries Ineligible for Health Insurance Under Selected Insurer Plans

Amusement parks
Aviation
Auto dealers
Barber and beauty shops
Bars and taverns
Car washes
Commercial fishing
Construction
Convenience stores
Domestic help
Entertainment/athletic groups
Exterminators
Foundries
Grocery stores
Hospitals and nursing homes
Hotels/motels
Insurance agencies
Janitorial services
Junkyards/refuse collection
Law firms
Liquor stores
Logging or mining operations
Moving companies
Parking lots
Physicians' practices
Restaurants
Roofing companies
Security guard firms
Trucking firms

SOURCE: General Accounting Office, "Firms Seek to Cut Health Insurance Costs," Washington, D.C., 1990.

BARNEY TRAXEL/NYT PICTURES

Susanne Dotson was willing and able to buy insurance but could not get it because of a preexisting condition.

Susanne Dotson could afford a substantial insurance premium. At 45, she earns $72,000 a year as a self-employed manufacturing representative for an office furniture distributor. Yet no insurer will take her due to a preexisting condition. Like many small employers and individuals seeking coverage, Susanne Dotson is in a bind—and concerned.

Ms. Dotson had been insured through her former husband's Blue Cross/Blue Shield plan. The company covered her despite a longstanding gynecological condition for which she had been treated, and which should be resolved as she enters menopause.

After her divorce, Ms. Dotson applied for Blue Cross/Blue Shield coverage in her own name through an organization that helps small businesses purchase health insurance. She was turned down due to the same condition for which they covered her previously. And she has found no other company is willing to insure her.

"I can go bare and hope that nothing happens or . . . go back and work for a corporation that would provide me coverage," Ms. Dotson stated before the Commission. "It's sort of ironic that in a country that encourages women and minorities to go forth and to take care of themselves, and celebrate[s] us as being small business owners, I don't really have a lot of choices."

Small firms, regardless of their line of business, also face an additional barrier to coverage: medical underwriting, or the practice of designing plans according to the medical history of the potential enrollees. For groups of fewer than 10 or 15 workers, an insurer may require medical information about each employee. If some members of the group are determined to present high risks, the insurer may follow any of a number of courses:

- The whole group may be denied coverage,
- The insurer may offer coverage to the group only if the high-risk employees are excluded,
- The insurer may permit the inclusion of these employees but increase rates to the entire group.

Even if the group is not determined to be especially high risk, other limitations may apply. The policy may exclude coverage for preexisting conditions—problems that were already diagnosed at the time the policy took effect but that may not have been known to the insurer—or it may impose a waiting period before coverage begins. Another limitation is to offer coverage only on a nonguarantee issue basis, meaning that the insurer makes no guarantee that it will offer the same policy to the group when the contract expires. Many small group policies also require minimum participation levels to guard against the possibility that only the higher-risk, more costly employees will participate. For the very smallest groups the policy may stipulate that 100 percent of eligible workers must enroll. To achieve these participation levels, employers must limit the share of premiums paid by the employees themselves to make the plan affordable. Very small employers may even be required by the terms of their policies to pay the entire premium.

Small employers who clear all these hurdles and obtain health coverage are *still* likely to pay 10 percent to 15 percent more than larger groups for an equivalent plan. This difference is generally not attributable to differences in the cost of benefits, but to the higher administrative costs involved.

For the smallest plans (one to four employees) administrative expenses can equal as much as 40 percent of claims. They drop to 35 percent for groups of five to nine, 30 percent for groups of 10 to 19, and 25 percent for groups of 20 to 49. Total administrative expenses of the largest conventionally insured plans (10,000 and more employees), by contrast, average 5.5 percent of claims. In self-insured plans, which are generally not an option for small employers because they are too small to take the risk, administrative costs can be as low as 2.5 percent of claims.[15]

In addition to general overhead items, which are fixed and therefore have to be spread over fewer enrollees, certain cost components are especially likely to be higher for small groups. The first is the commission paid to the insurance agent or broker who sells the policy. This averages 8.4 percent of claims for a group of fewer than five enrollees, and less than 1.0 percent of claims for groups of 500 or more. A second is the risk or risk and profit charge, which includes both the insurer's profits and some cushion against unexpectedly high claims cost. The risk charge averages 8.5 percent for groups of fewer than five, in sharp contrast to 3.5 percent or less for groups of 500 or more.[16] Small groups face higher risk charges in part because costs for these groups may be less predictable than for larger ones. But smaller groups also pay a higher risk charge because of their limited bargaining power.

In addition to facing higher initial costs for coverage, small employers sometimes find that their premiums increase sharply after the first year of coverage. A group may start out with a healthy pool, since the group members with a known, immediate need for health services have been excluded. Over time, however, those left in the pool will gradually use medical care at higher rates, leading to increasing costs claimed under the policy. Accordingly, many insurers raise the rates after the first year of the policy. (Some may offer, as an alternative, to re-underwrite the

A child born with a birth defect causes family pain. It can also wreak havoc with one's health insurance. Listen to Cheryl Gresek, whose son Daniel had a rare heart problem: "When you have a child born with a defect like this," she told the Commission, "it rips your whole world apart. There is an enormous amount of stress."

COURTESY OF NORTH SHORE WEEKLIES

The Greseks faced skyrocketing premiums due to their son Daniel's need for care—just when insurance became essential.

Mr. and Mrs. Gresek were covered under a group health policy through their small, family-owned business in Ipswich, Massachusetts. Once the insurance company began getting bills for Daniel's care, however, the couple saw their monthly premiums skyrocket from $198 to $766. Their employees' premiums increased by this amount as well.

To keep the business going, the Greseks took pay cuts. And although they had always offered their employees insurance, they were forced to drop it. The couple continued to pay the premium increase for themselves, plus a $1,100 annual deductible. Otherwise, they couldn't have paid for Daniel's care. By the time he was two, the medical bills totaled $300,000. The family premium continued to soar, from $766 monthly to $1,375. The Greseks finally had to drop the policy.

"What amazes me is that we hear so much about getting the uninsured insured and here we are, willing and able to pay a reasonable amount for insurance and we are forced off," Mrs. Gresek testified. "Our only fault was having a sick child."

The Greseks eventually found a state program that provides coverage for the disabled at reasonable rates, and they are once again offering insurance to their employees. But the couple is still angry at their former insurer. Said Mrs. Gresek, "At a time we should have been totally concentrating on Daniel and our family, we had to put so much time and effort into our insurance problems. They put us through hell."

group, again separating the currently sick from the currently healthy.) Insurers may also quote artificially low rates for the first year in order to gain new business.

One other rating practice that was once rare in the small group market but now appears to be gaining currency is some form of group-specific rating, especially for years after the initial year of the policy. Experience rating, in which premiums are based on actual costs for the particular group, is still uncommon in the small group market. However, some insurers may classify small employers into broad ranges, or tiers, by claim experience. A group with unexpectedly high costs during a year may be reclassed into a new, higher-rate tier.

Finally, employers who present the best risks may respond to annual rate increases by seeking a new insurer who will offer a more affordable first-year rate, a process known as churning. As a result, while insurers are competing more vigorously for the groups that present more favorable risks, their renewal business may increasingly consist of higher-risk groups unable to find a lower price. This spiraling process, which makes insurance less and less affordable for the higher-risk groups, has accelerated in the past decade.

Defects of Public Health Care Coverage

Government provides health coverage for low-income people through the federal/state Medicaid program. Medicaid has accomplished a great deal: its enactment undoubtedly improved access to care for the segments of the poor population it has reached. But basic flaws in the design of Medicaid prevent it from covering many of those who need help. Some states have tried to fill in with other programs of their own. But funding limitations and other problems prevent these programs from helping most of the millions of poor people without health coverage.

Medicaid—Medicaid provides coverage to about 26 million people who are aged, blind, disabled, or members of families with children. Each state designs and administers its own Medicaid program within broad federal guidelines.[17] The federal government pays an average of 55 percent of the cost of the program, a share that ranges from 50 percent to 80 percent depending on a state's per capita income. Combined federal and state expenditures for the program are expected to reach $70 billion in fiscal year 1990, just over half of which (55 percent) will go for hospital, physician and other acute care services.[18, 19]

Medicaid does not reach more than a fraction of the low-income population. In 1987, just 42 percent of people in poverty were covered. Even among extremely poor people—those with family incomes below 25 percent of the poverty line—nearly a quarter did not receive Medicaid or any other coverage in that year.[20]

There are two reasons why so many low-income people do not get Medicaid coverage. An applicant not only must meet income and asset tests to qualify, but also must be in one of the protected populations defined in Medicaid law. Medicaid was designed to cover the welfare population—families with children receiving Aid to Families with Dependent Children (AFDC) and aged, blind, and disabled persons receiving Supplemental Security Income (SSI). Although current law defines some 40 different population groups potentially eligible for Medicaid coverage, either by federal mandate or under state option, all Medicaid beneficiaries must be aged, disabled, or members of families with children. Almost three out of four Medicaid beneficiaries are welfare recipients.

> ***"Obtaining the benefits one is entitled to by law is not easy. It can be a time-consuming, complex, and demeaning journey. I have three documents here with me today. . . . One is an application for food stamps. It's 10 pages. On the second page of the application there are 38 questions. This is an application for [Supplemental Security Income] benefits. It is 15 pages long. I quit counting the questions at 100. This is an application for a $100,000 home mortgage. It's three pages long."***
>
> ***—Herb A. Sanderson, deputy director,***
> ***Division of Aging and Adult Services,***
> ***Arkansas Department of Human Services***

Completely omitted from the program, even if they are literally penniless, are single people and childless couples who are under 65 and do not meet disability tests. And within the protected populations, Medicaid rules continue to use distinctions and exclusions carried over from the welfare programs. An intact, two-parent family headed by a full-time worker, for example, cannot be covered as a family. The children may be covered and the mother is eligible during the period of a pregnancy, but the father is never eligible.

Along with these complex categorical exclusions go enormous variations in the financial standards imposed by the states. For many of the eligible groups there are no minimum federal standards. A family of three in California could get Medicaid in 1990, for example, with a monthly income of up to $934, about 106 percent of poverty. The same family could get Medicaid in Alabama in 1990 only if its income was $118 a month or less. This cutoff is just 13 percent of poverty.[21] Further aggravating the disparities, many states fail to adjust their financial standards adequately to reflect inflation, making the real standards more restrictive over time. The median state AFDC payment level, which determines family Medicaid eligibility limits in many states, *dropped* 30 percent in real or inflation-adjusted dollars between 1970 and 1988.[22]

In the last several years, the Congress has mandated coverage up to higher income levels for a few groups, beginning to separate eligibility for Medicaid from eligibility for welfare. The major focus since 1984 has been on expanding eligibility for pregnant women and young children. The most recent expansion, the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), requires states, beginning April 1990, to cover pregnant women and children under age six with

The consequences of having no insurance can be devastating. Diana and Melvin Seeger of Grand Rapids, Michigan, know this only too well.

MORIAL
SPITAL

Diana Seeger could not qualify for Medicaid or afford care at a hospital close to home; her baby sustained brain damage at birth.

Mr. Seeger's job as a logger did not provide insurance. And, although he earned just $9,000 a year, the couple's assets made them ineligible to qualify for medical assistance. So Mrs. Seeger couldn't afford to go to either of two hospitals within 20 minutes' drive of their home for the delivery of their third child. Instead, they chose a more affordable hospital an hour and a half away.

On their way to the hospital, Mrs. Seeger went into labor shortly after leaving home. The couple wound up at an Indian out-clinic unequipped to handle deliveries. The baby was deprived of oxygen and as a result was severely brain damaged.

After spending most of his first year in the hospital, their son David was released to medical foster care. Rehospitalized several times for surgery, David died when he was three and a half years old. "It's really tragic," Mrs. Seeger told the Commission. "Had we had health insurance or been eligible for medical assistance, we could have gone to a closer hospital, and David would be alive today."

The bitter irony for the Seegers is that David's care cost $183,000—all of which was paid by medical assistance. Both prenatal and maternity coverage would have cost $2,000—a fraction of that amount. "[A]n entire family went through months of counseling and years of agony," Mrs. Seeger testified before the Commission, and "a baby suffered for three and a half years. In a country that is rich in resources, our baby's life was taken because someone thought they could save $2,000."

family incomes up to 133 percent of poverty. It is too soon to know the full effect of the 1989 changes, but preliminary CPS data for March 1989—reflecting the earlier phases of the eligibility expansion initiative—indicate that the number of poor children covered by Medicaid may actually have *dropped* between 1987 and 1988.[23] The fear is that the effects of expanded coverage for younger children have been outweighed by steadily more restrictive standards (again, in real dollars) for older children. In addition, not all members of the newly eligible populations are actually applying for coverage, since both stigma and administrative barriers deter participation.

Congress also helped Medicaid recipients who lose their eligibility for the program when their income increases.[24] In 1988, Congress required states to continue Medicaid coverage for a year for this group of beneficiaries. While these people are obviously helped by the extended benefits, when their Medicaid coverage ends, they often face a dilemma: working for higher income but receiving no health benefits or slipping back onto the cash assistance program in order to qualify for Medicaid.

All state Medicaid programs, by federal mandate, must cover a basic set of services, including inpatient and outpatient hospital care and physician, laboratory, and X-ray services. Most states also cover a variety of optional services, such as prescription drugs (covered in all states) and dental care. However, on mandatory as well as optional services, states are permitted to restrict the amount of the service, for example, the number of inpatient hospital days or physician office visits, that Medicaid will cover in the course of a year.

Even if the state nominally covers a service, beneficiaries may find that doctors or other providers are unwilling to accept Medicaid or have limited the numbers of Medicaid patients they will serve, largely because Medicaid's reimbursement rates are so low.

For physician services, Medicaid rates are consistently well below those paid by Medicare or by private insurers. In 1986, for example, the maximum Medicaid payment for an appendectomy averaged 61 percent of the Medicare maximum in the same state. Of 47 states reporting, 14 reimbursed physicians at a rate below 50 percent of the Medicare maximum. New York paid just 14 percent of that maximum.[25] Obstetricians are especially reluctant to provide deliveries to mothers on Medicaid, claiming that the Medicaid payment rate often will not cover even the cost of the malpractice premium associated with the delivery.[26]

ERIC FUTRAN

Older children may lose Medicaid coverage as the federal government expands coverage for the very young.

The effect of Medicaid reimbursement rates on access to other services is less clear.[27] There is no statistical evidence that Medicaid patients face widespread barriers to hospital care, although there are anecdotal accounts that some hospitals discourage or refuse Medicaid admissions.[28] Hospitals frequently report that states' Medicaid payment rates are less than the cost of care.[29] Where this is true, hospitals' willingness to continue accepting Medicaid patients may depend on their ability to make up for Medicaid losses by increasing their private rates. It is possible that recent pressure by private payers for discounts is limiting the capacity of hospitals to engage in such cost shifting. If so, Medicaid beneficiaries, like uninsured patients, could face barriers to care.

Other Public Health Coverage Programs—Many states operate partially or wholly subsidized programs for persons who are not eligible for Medicaid coverage.[30] These include programs for low-income persons who cannot qualify on categorical grounds, and programs for persons at medically high risk. In some states these programs provide benefits as comprehensive as those furnished by the Medicaid program. In other states benefits are much more limited. States may operate the programs directly, or the programs may be administered and partially or wholly funded at the county level.

According to the Intergovernmental Health Policy Project, 22 states sponsored general assistance programs in 1987, providing medical benefits (and usually cash welfare) to very low-income persons who do not meet categorical tests, such as single men. These states reportedly spent more than $1.66 billion on such programs in 1987. Twenty states operated comparable medically indigent programs for other target populations.[31]

General assistance and other medically indigent programs are often called state-only programs, because they are financed without federal assistance. One 1985 survey found that state general assistance and state-only medically indigent programs covered about 1.3 million people.[32] More recent data on the total number of persons covered by these programs are not available.

State-only programs have many of the same problems as Medicaid, compounded by the lack of federal funding. Financial eligibility standards are often even more restrictive than those used for Medicaid, program benefits often more limited, and reimbursement levels often lower. For example, the Illinois general assistance program paid hospitals a flat $500 per admission in 1983, at a time when the state's Medicaid program was paying an average of $274 per day. One study found that enrollees in the general assistance program were refused care by Chicago-area hospitals almost as often as the uninsured.[33]

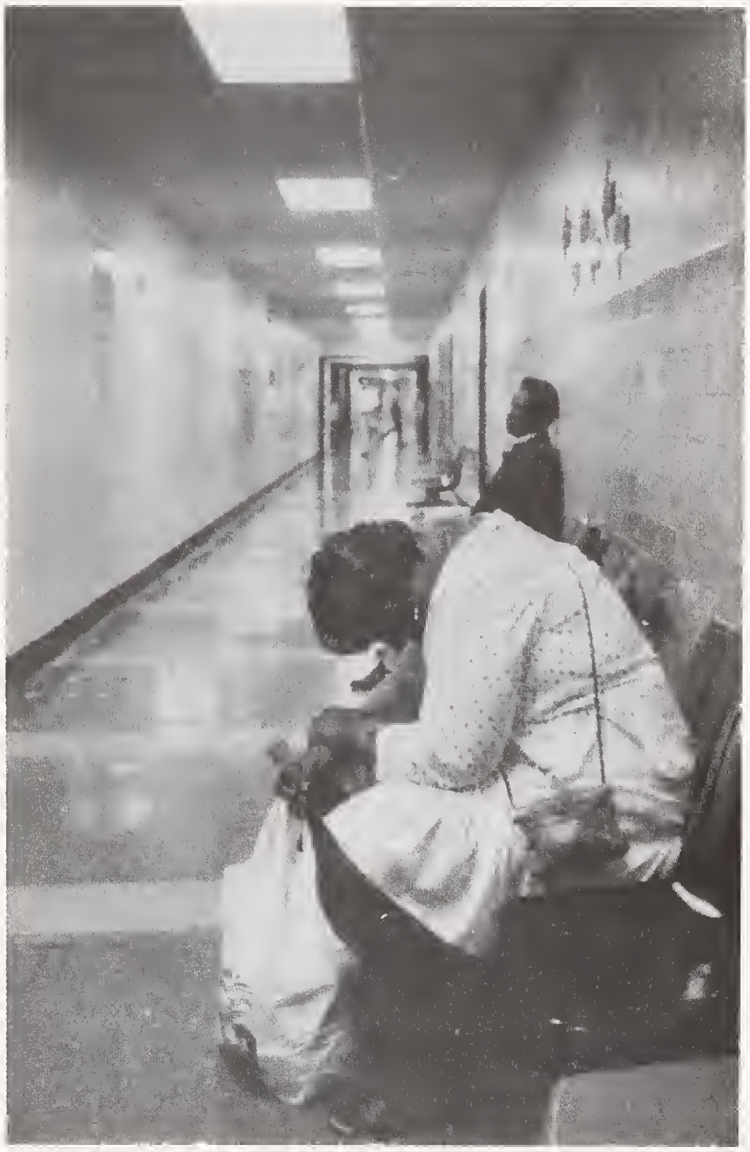
Some states have also developed programs aimed at individuals who are not necessarily low income but who cannot purchase insurance in the private market because they present high medical risk. In some states, public funds are used to help subsidize the programs and make premiums more affordable for participants. In others, the programs are supported through contributions by health insurers, who are thus in effect pooling the cost of covering high-cost individuals. State programs for the uninsurable have thus come to be known by the general term risk pools, even though not all programs use this method of financing.

These programs tend to attract a small number of extremely costly enrollees. As of the end of 1988, risk pools were operational in 13 states, with a total enrollment of about 30,000 members.[34] The extremely limited enrollment is partly because many of the programs are inadequately publicized and partly because, even when premiums are subsidized, the rates are often beyond the reach of most people needing coverage. In some pools, for example, rates are set at 125 percent or more of the average cost of nongroup coverage in the state. Despite these high rates, most pools suffer large losses.[35] A pool consisting only of sick people cannot rely on the sharing of risks that might be possible if a program enrolled a representative sample of the community. Such a pool must find some external form of subsidy. The growth of state risk pools is therefore directly constrained by the willingness and ability of states (or insurers within the states) to finance them.

WHAT CARE DO THE UNINSURED GET?

More than 13 million people, 6 percent of all Americans, were unable to obtain needed medical care according to a 1986 survey estimate, because they did not have adequate financial resources. And an estimated 1 million Americans tried to obtain needed medical care but were turned away by doctors or hospitals for financial reasons.[36]

Just how much less care do the uninsured receive and who pays for the care they get?



EARL DOTTER

In 1986, doctors and hospitals turned away 1 million Americans for financial reasons.

Service Use

Compared with the insured in 1986, the uninsured contacted the doctor only two-thirds as often and used only three-quarters as many hospital days (see Figures 1-9 and 1-10).[37] Even after correction for age, sex, and income differences between the two groups, the uninsured typically use fewer services than comparable insured persons.[38] The 1986 survey quoted earlier found that uninsured people with serious symptoms—such as unexplained bleeding or periodic loss of consciousness or fainting—saw physicians only half as often as similarly ill people who had insurance.[39]

Even when the uninsured get care, they may receive different or less care than the insured for similar conditions. Two recent studies provide evidence here. One found that insurance status is a significant factor in determining whether a cancer patient receives surgery, is given a different anticancer treatment (such as chemotherapy without surgery), or receives no active treatment at all.[40] The other study found that uninsured patients had shorter stays in hospitals and underwent fewer procedures than Blue Cross patients

When crises struck, Pamela and Tommy Young, an uninsured couple from Dickson, Tennessee, resorted to drastic measures to obtain health care for their children.

TURNER HUTCHINSON/NASHVILLE BANNER

Pamela Young, uninsured, struggled to get care for her son Jonathan when he needed it.

Their daughter Mary required hospitalization but, without health insurance, this was unaffordable. In desperation, Mr. Young moved in with a relative, while his wife filed for a trial separation to qualify the children for Medicaid. Mary was hospitalized and her father later moved back home. Although uncomfortable with such actions, Mrs. Young told the Commission, "It was the only way we could think of to ensure that Mary would get the care she needed."

Another time, the couple's son Jonathan—suffering from abscesses due to infection—led to an odyssey with medical care. An emergency room nurse in a nearby major hospital recommended surgery. "But when the hospital discovered that we had no insurance, they did not want to take him," Mrs. Young said. Her assurances that they could pay, since both worked, were unheeded. Mrs. Young persisted; her son was treated as an outpatient and advised to come back for follow-up care. Yet on their return, the problem recurred.

"Because we didn't have any insurance," she said, "they didn't want to treat Jonathan." So Mrs. Young took her son to other area hospitals, pediatricians, even a public clinic for the homeless for care. All refused since the first hospital had begun the process. She was about to drive home to Indiana and her old pediatrician when a public health clinic attorney arranged for treatment at the original hospital.

The Youngs owe this hospital $4,000—and they pay as they can. Realizing they couldn't risk living without insurance, Mrs. Young quit her management job and now stocks shelves at a variety store because it provides health insurance for the entire family.

and also had shorter stays than Medicaid patients (although they received a similar number of procedures). This was true even though the conditions of the uninsured were as severe as those of other types of patients.[41]

For those who have no insurance and cannot pay, primary care is often particularly difficult to obtain. The uninsured are twice as likely as the insured to lack a regular source of medical care.[42] In addition, they are more likely to delay care.[43] Such delays can lead to more serious illness, avoidable hospital admissions, and avoidable deaths.[44, 45]

The uninsured perceive themselves to be in poorer health than those with health insurance. In one national survey, 10 percent of the uninsured reported that they were in poor or fair health, compared with 7 percent of those with health insurance. Only 61 percent of the uninsured reported that they were in very good or excellent health, compared with 72 percent of those with health insurance.[46]

Their perceptions, tragically, are grounded in fact. One recent study found that infants born to parents without health insurance are 30 percent more likely to become ill or die than those born to insured parents.[47] An important factor in this difference is access to prenatal care. One in five uninsured pregnant women surveyed in 1986 did not seek medical care early in her pregnancy.[48] And the number of babies born to women who did not seek prenatal care grew nearly 10 percent between 1979 and 1988.[49] As was noted above, Congress has recently acted to make prenatal care available to more of the very poorest women. But more remains to be done.

ST. JOHN'S HOSPITAL/SPRINGFIELD, ILLINOIS

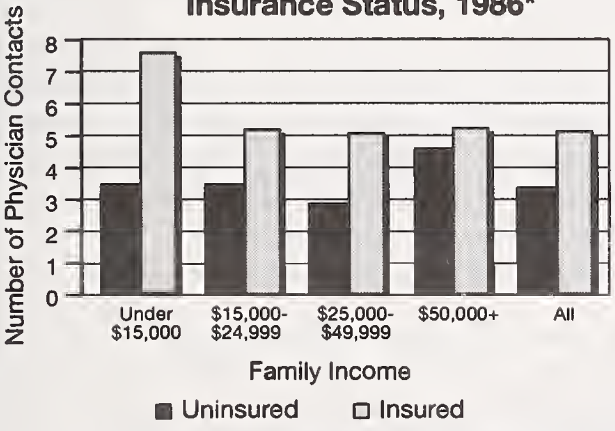
Lack of insurance means too many babies are born too soon, too small, and too sick.

Lack of health insurance means diminished chances at the outset of life and more illness and disability ahead. The short-term costs of solving these problems are far outweighed by the long-term costs—to the health of our citizens and the productivity of our society—of continued neglect.

Sources of Care for Those Who Cannot Pay

A limited safety net of public subsidies and private charity has until recently been able to meet at least the most urgent health care needs of most citizens. This informal system is now under severe strain, and we can no longer be sure that every American can obtain care even in an emergency. What follows is a

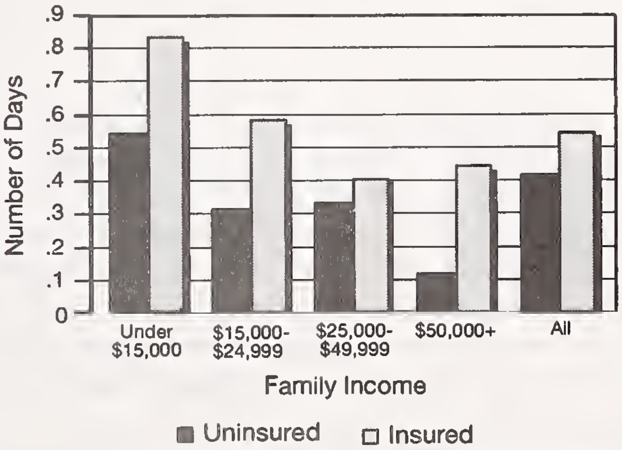
Figure 1-9 Average Reported Physician Contacts, by Income and Insurance Status, 1986*



*Contacts include telephone calls to physicians and house calls as well as visits to the doctor's office, a company-based clinic, a hospital emergency room, or a hospital outpatient facility.

SOURCE: Congressional Research Service analysis of data from National Health Interview Survey, 1986.

Figure 1-10 Average Reported Hospital Inpatient Days, by Income and Insurance Status, 1986



SOURCE: Congressional Research Service analysis of data from National Health Interview Survey, 1986.

look at our indigent care system and the factors threatening it.

Public Health Programs—Although all levels of government make some contribution to the care of the uninsured through subsidies or direct provision of health services, their efforts are inherently limited in scope.[50] Federal programs established in the 1960s and 1970s have faced steadily declining resources throughout the 1980s. State and local programs similarly face resource constraints.

The main federal efforts are grant programs:

- The Maternal and Child Health Services block grant to states, to provide preventive, primary, and specialized care to low-income women and children;
- The Community Health Center program, which provides direct support to urban and rural community health centers that furnish primary and prenatal care and other health services to medically underserved populations;
- The Migrant Health Centers program, whose grantees provide care to migrant and seasonal farm workers;
- The Preventive Health Services block grant to states, for discretionary use for any of several specified preventive health priorities;
- A variety of other programs and grants targeted to specific populations (the homeless, those in rural areas) or health care needs (family planning, black lung disease, AIDS).

The Public Health Service administers these grants, which help state and local governments and private nonprofit organizations provide facilities, services, and personnel for underserved populations. In most cases, federal monies are combined with state or local government funds, private funds, or insurer payments.

How many persons are being served by these programs is not clear. But it *is* clear that the programs do not fully meet the needs of the populations they are intended to serve—let alone all those not covered by public or private insurance. The migrant health centers are estimated to serve only 14 percent of the migrant population—about half a million of the 3.5 million migrant workers and their families.[51] Community health centers are estimated to reach 5.35 million persons (not all of them uninsured)—or about 15 percent to 20 percent of the 25 million to 30 million persons living in the nation's medically underserved areas.

Limited funding is the primary reason these programs are falling short of their mission. Total funding for all the direct health services programs listed here is just under $1.5 billion in 1990.[52]

But even if they were fully funded and successfully reaching all their target populations, these federal public health programs would not fill the gaps left by private and public health insurance. They are aimed at specific groups and specific problems, and the range of services they provide is sharply limited. None of the programs, for example, includes inpatient hospital care.

One other federal initiative deserves mention in the context of care for those who cannot pay: the Hill-Burton program, which provided support for hospital construction and renovation in exchange for a commitment by the hospitals to provide free care and below cost care to persons with incomes less than 200 percent of poverty. Although no new grants and loans under this program have been made since the mid-1970s, some of the facilities that received assistance have ongoing obligations to provide at least some free care into the 1990s. A few are obliged to provide free care throughout their existence. And all Hill-Burton-assisted facilities are prohibited from denying emergency services to community residents on the grounds of inability to pay (however, they may bill for services rendered).[53] There have been serious questions about the adequacy of enforcement of the Hill-Burton free care requirements, however, and, in any event, the obligations are tiny compared with the need. The total amount of free care that such hospitals are obliged to provide is $180 million in 1990; and only $1.8 billion in additional care is required over the remaining life of the program.[54]

State, county, and municipal governments finance, subsidize, or furnish indigent care—or require providers to furnish it—in a variety of ways. In all but three states, either state or local government has at least some legal obligation to provide indigent care to some patients.[55] In 18 states, the responsibility falls solely on the counties. In four others, counties have this responsibility only if they operate a hospital; otherwise the responsibility belongs to the state. In eight other states, responsibility is shared between counties and state or city governments.[56]

The state or local insurance programs for non-Medicaid low-income or medically uninsurable persons described earlier account for only part of state and local spending for the uninsured. Additional funds go to direct support for the provision of services, chiefly in public hospitals and clinics, and primarily in the South and South Central regions.[57]

State and local subsidies for hospital services alone were an estimated $3.1 billion in 1988, according to the American Hospital Association (AHA). Of this amount, $0.7 billion went to support facilities that were wholly reliant on public or charitable funds. The remaining $2.4 billion was in the form of subsidies to facilities that also received payment from insurers and patients.[58] The extent of state and local assistance for nonhospital services is less clear. Overall, states spent $1.9 billion of their own funds on personal health programs in 1987; local health departments spent another $0.9 billion (not counting state subsidies).[59]

These funding levels, which do not all go for care of the uninsured, fall grossly short of the need. Even public hospitals can no longer rely on local government to make up their full losses on uncompensated care. The National Association of Public Hospitals (NAPH) has estimated that its member facilities would average a 30 percent operating deficit without public subsidies, and have a 7 percent deficit even with the subsidies.[60] This is not for want of effort by local governments. The Prospective Payment Assessment Commission (ProPAC) has noted, for example, that state and local appropriations for public hospitals rose 41 percent between 1980 and 1984. Public hospitals' costs for the uninsured almost doubled in the same period.[61]

Two factors appear to have contributed to the growing burdens on public facilities. The first is greater demand—not just the rise in the number of uninsured persons, but also new pressures such as the AIDS epidemic, widespread drug abuse, and violent crime. The second is the erosion of privately subsidized care in private or nonprofit hospitals. This includes care given to patients who are not expected to pay (traditional charity) and bad debt from patients who were expected to pay when care was provided.

Charity Care—Traditional charity and bad debt are discussed together for two reasons.[62] First, data limitations make it difficult to distinguish between the two. Second, and more important, studies indicate that most bad debt is incurred by persons without adequate insurance who would have difficulty paying substantial bills.

Uncompensated care furnished by hospitals is the focus of this discussion because the extent of hospital services to the uninsured is fairly well documented. It should be emphasized that physicians and other providers also provide uncompensated care. As much as 10 percent of all physicians' services may be going to patients without charge or insurance payment.[63]

Uncompensated care cost hospitals $10.7 billion, 6.3 percent of total expenses in 1988 according to the AHA. The extent of the private subsidy—uncompensated care minus state and local contributions—amounted to $8.3 billion or 4.9 percent of total expenses, in 1988. Hospitals are providing more free care than they were at the start of the decade, when the equivalent figure was $3.0 billion, or 3.9 percent of total expenses.[64] But their ability to continue to afford this burden is in grave doubt.

Providers of care cover their losses on uninsured patients from their charges to those who can pay. This means that employers and insurers are paying much of the cost of uncompensated care. They are increasingly looking for ways to avoid this hidden tax through preferred provider organizations (PPOs) and other negotiated discount arrangements, which successfully restrict their liabilities to their own workers or subscribers.

With the Medicare and Medicaid programs also restraining payment rates, hospitals are steadily losing the cushion they need if they are to finance care for those who cannot pay.

Shrinking finances are not the only cause for alarm. As the ability to finance uncompensated care is going down, the need for such care is increasing. Drug abuse, AIDS, and violent crime are all disproportionately concentrated among the poor, who are most likely to be uninsured. So, too, is the problem of low birthweight babies. By late 1989, one in 10 of all infants born alive in New York City required neonatal intensive care, at enormous cost.[65] And in some parts of the country, the special needs of low-income groups are compounded by the need to provide care to a growing population of undocumented immigrants, who are almost entirely excluded from all health care coverage.

When resources are limited, even hospitals committed to serving the poor and uninsured limit the care they provide.[66] Other hospitals are eliminating the services most likely to attract medically indigent patients—such as emergency rooms and trauma centers. This trend may be curtailing access to care for the adequately insured population as well. In some areas, for example, hospitals are dropping out of regional trauma systems because a high proportion of the patients treated in those systems lack coverage. Everyone must travel farther for emergency care as a result.[67]

IS OUR HEALTH CARE SYSTEM IN JEOPARDY?

The strains on our system of public subsidies and charity care are the symptom of a larger problem. Explosive increases in health care costs are beginning to jeopardize access to care even for adequately insured Americans, and whether we are getting full value for our health care dollar is being increasingly questioned.

Rising Costs

Since 1960, health care expenditures have increased over 800 percent, growing annually more than twice as fast as general prices. In 1960, health care expenditures were 5.2 percent of gross national product (GNP); by 1988, health care expenditures had reached 11.1 percent of GNP, or $540 billion.[68] Expenditures are expected to reach 15 percent of GNP by the year 2000.[69] Since 1965, health care spending has tripled as a share of government revenues and business receipts.[70] Compared with general inflation rates, health care spending increased faster in the 1980s than in the 1970s, despite unprecedented efforts by all major purchasers to control their costs. Several key factors contribute to this escalation.

> ***"If we examine the health systems other countries have adopted, while they vary widely, we find two common denominators. They provide protection for all their citizens, and they have effectively established a process which provides some measure of control over how much of a country's resources its health system can consume. Now while the U.S. health care system has many, many wonderful attributes, these two features are missing. . . . [W]e can embrace them without detracting from the good our system has to offer."***
>
> *—Walter B. Maher, director,*
> *federal relations, Human Resources Office,*
> *Chrysler Motor Corporation*

First, for the majority of Americans with adequate health insurance coverage, the very presence of that coverage shields them from the costs of the medical care they obtain and may sometimes encourage use of unnecessary or wasteful services.

Second, various pressures encourage providers to furnish care even when they are not certain it is necessary. Many payers continue to use reimbursement systems that reward providers for increasing their patient load or intensifying the services they provide to each patient. And as described below, fear of malpractice liability and uncertainty about the benefits of alternative treatments make physicians loath to withhold a service in case it should prove beneficial.

Finally, advances in technology are costly. New technologies based on advances in biology, pharmacology, physics, and engineering have brought about measurable improvements in the length and quality of life, but they are not cheap. Many innovations can transform the practice of medicine for the better, even though payment methods and uncertainty can encourage their overuse. Some observers believe that technology may be the major factor driving increases in medical care costs over the long term, and that we may eventually have to choose between ever higher expenditures, on the one hand, and slower adoption of new treatments, however beneficial, on the other.

Employer Costs and Responses

As the purchasers of insurance for most Americans, employers are under enormous pressure to cope with rising health care costs. In 1965, employer-paid group health insurance represented 2.1 percent of total labor compensation; by 1987 it had tripled to 6.2 percent. In 1987, health spending was equivalent to over 94 percent of after-tax profits, compared with about 14 percent in 1965 and 74 percent in 1984.[71] Although full data for the most recent years are not yet available, private industry has been reporting insurance premium increases over the last three years, in the range of 15 percent to 25 percent.[72]

Such dramatic increases not only impede efforts to improve access to health care but may erode the access we now have.

Employers have responded to rising costs by turning to managed health care. By 1989, 27 percent of employees with health coverage were enrolled in health maintenance organizations (HMOs) or preferred provider organizations. Many more were in plans that required prior approval of hospital admissions or a second opinion before elective surgery.[73]

Employers have also turned to an alternative strategy: shifting more of the expenses to their employees.

One way of doing so is to increase the cost sharing—deductibles and coinsurance payments—enrollees must pay before coverage under the health plan begins. In the 10 years 1977 to 1987, the proportion of employees with first dollar coverage for physicians' services declined from 15 percent to 5 percent. The number of workers having to pay less than 20 percent coinsurance dropped from 80 percent to 41 percent in the same period.[74] Although the most prevalent deductible in employer-sponsored insurance remained $100 from 1980 to 1988, the number of participants with a deductible of $150 or more rose from less than 10 percent to 40 percent.[75] Many would applaud these benefit changes, on the grounds that they encourage employees to be more responsible in the use of health services. Moreover, these changes were accompanied by an additional benefit: increases in the number of workers in plans that limit potential out-of-pocket costs for enrollees, enhancing "catastrophic" protection.[76]

More troubling is increasing reliance on a second way of shifting costs to employees: reducing the employer's contribution to the basic insurance premium. The proportion of employees paying $30 or more per month for individual coverage rose from 3 percent in 1986 to 13 percent in 1988. For family coverage, the proportion paying $100 or more per month went from 5 percent in 1986 to 16 percent in 1988. Average employee payments for their own coverage rose 32 percent between 1988 and 1989, while the workers' share for family coverage rose 20 percent.[77]

Employers' cost saving efforts have begun to arouse employee resistance and have become a major source of labor unrest. Health care concerns were at the root of an estimated seven out of eight of the nation's labor-management disputes in the last two years.[78] This trend can be expected to continue.

> ***"Ultimately, health care costs cannot be controlled at the bargaining table. Thus CWA and the IBEW also proposed that [AT&T] work with us to promote and achieve health care reform."***
>
> ***—James Irvine, vice president,***
> ***Communications Workers of America***

Growing anxiety about the burden of retiree health benefits compounds the pressure employers face. Many businesses provide full health coverage to retirees who have not yet reached age 65 and supplemental coverage to retirees who are eligible for Medicare. But future health benefit obligations do not have to be fully funded or carried as a liability on corporate accounts, unlike pension benefits.

> ***"We are a large company, with more than 300,000 employees. The CWA and the IBEW are large unions with hundreds of thousands of members. Out of this last round of bargaining came the realization that, as large as we are, the health care dilemma is bigger than AT&T and its unions. It's truly a national issue."***
>
> ***—Charles Brumfield, director,***
> ***labor relations, AT&T***

The General Accounting Office (GAO) has estimated that, as of 1988, the unfunded health benefit liability for persons already retired was $221 billion, and the potential liability if corporations were to keep their promises of retiree health benefits for their active employees was $402 billion.[79] The Financial Accounting Standards Board (FASB), whose minimum requirements for corporate accounting are widely used, has decided that the future obligation for retiree health benefits should be shown as a liability on corporate accounts. If the FASB's decision is followed, and these enormous obligations must be added to corporate accounts, some of America's largest businesses could become technically insolvent—a threat that increases the pressure on employers to find some way of reducing their health care liabilities.

Both labor and management, then, must view rising health care spending as an increasing threat to their economic well-being.

Are We Getting Value for Our Dollars?

The United States spends a greater proportion of its wealth on health care than any other country. United States health care expenditures as a percentage of gross domestic product (GDP) have been substantially higher than in any of the other 23 members of the Organization for Economic Cooperation and Development (OECD), which includes other Western industrial nations. In the United States, health expenditures as a percent of GDP were 10.8 percent in 1987.[80] In other countries, health care spending as a percentage of GDP ranged from a low of 5.3 percent in Greece to a high of 9.0 percent in Sweden. Canada and France each spent 8.6 percent. On a per person basis, the United States spent $2,051, while Canada, the next highest, spent $1,483.[81]

With costs so high and continuing to rise, Americans have come to question whether we are getting our money's worth. Even with such high health care spending the United States falls behind many countries that spend much less on health care, as measured by infant mortality, life expectancy, age-adjusted mortality, and other basic health indicators. In 1986, for example, the infant mortality rate for the United States was higher than that of 21 other countries, including Singapore, Spain, Italy, and the German Democratic Republic.[82] In 1986, the United States ranked nineteenth in life expectancy at birth for males and fifteenth for females, behind such countries as Japan, Sweden, Canada, Greece and Spain.[83] Among the OECD nations, the United States ranked twelfth in total age-standardized death rates per 100,000 for the early 1980s, behind countries like Japan, Sweden, Canada, Iceland, and Greece.[84]

Mortality statistics for impoverished populations within the United States suggest that pockets of Americans fare worse than citizens of some of the world's poorest nations. Bangladesh is one of the lowest-income countries. Nonetheless, a recent study found that black men born in central Harlem, a low-income area in New York City are less likely to reach age 65 than men in Bangladesh. Women in Bangladesh, if they survived past the age of 10, also could be expected to live longer than women in Harlem. The high mortality in Harlem was partly due to the large amount of violent crimes and substance abuse in that community. But the greatest single source of the high mortality rate was cardiovascular disease, suggesting that lack of access to services contributed to these statistics.[85]

Care in the United States may be superior in many ways that are not measured in these gross statistics. And these statistics reflect many factors other than medical care. Still, as U.S. health care expenditures continue to rise, many question whether we are using our money wisely. Increasingly, these questions focus on the necessity and appropriateness of the medical care most Americans receive.

What Is Appropriate Care?

There is no single prescription for high-quality health care, and a wide range of practices may be accepted for specific conditions. Thus, a lot in medicine falls in the gray areas of uncertainty where a physician's judgment becomes critical.

The most striking evidence of the effects of uncertainty in medicine is found in research on geographic variations in practice patterns, or what is called "small area analysis." These studies have found significant geographical variations in average length of hospital stays, hospital discharge rates, and surgical procedures. Researchers discovered, for example, that the likelihood that a woman in Maine would have a hysterectomy by the time she reached 70 years of age ranged from a low of 20 percent in one community to a high of 70 percent in another.[86] In comparing the practice of medicine in Boston and New Haven (cities otherwise similar in medical resources and population health status), researchers found that Boston doctors were twice as likely to perform carotid endarterectomies but only half as likely to do coronary bypass surgery.[87] Boston physicians were much more likely to hospitalize Medicare patients than were their colleagues in New Haven.[88] Areas with a high frequency of procedures are not necessarily those providing a lot of inappropriate care. Sometimes, a small number of physicians in high use areas are performing a large number of procedures, judged to be appropriate given patient indications.[89]

These variations cannot be fully explained by differences in the health status of the populations or by standard physician characteristics such as age, specialty, or medical school. The most important factor seems to be differences in the practice styles of physicians.[90] While the resulting care may be appropriate, often the procedure chosen is not superior to alternative treatments in producing net benefits for the patient.

Which practice styles best produce desired patient outcomes is the central concern of appropriateness research (which is sometimes done within small area studies). This research uses a number of methods for identifying inappropriate use, including audits of medical records, second opinions for surgical procedures, and examination of pathology specimens after surgery.[91]

Such research has determined that common procedures such as angioplasty, coronary artery bypass surgery, cardiac pacemaker implantation, and Caesarean section deliveries, are often used without producing any medical benefit for the patient.[92] For example, 32 percent of carotid endarterectomies, 17 percent of coronary angiographies, and 17 percent of upper gastrointestinal endoscopies have been found to be inappropriate.[93] A review of the appropriateness literature by the GAO found that the inappropriate use of surgical procedures ranged from 14 percent to 32 percent, and inappropriate hospital admissions ranged from 7 percent to 19 percent.[94]

Unnecessary and inappropriate services not only waste the health care system's limited resources and deprive others of needed care but also pose risks to patients. An unnecessary Caesarean section, for example, can lead to infections, a prolonged hospital stay, and psychological distress for the newborn's mother. Inappropriate use of antibiotics may expose patients to unjustified side effects and result in the proliferation of antibiotic-resistant organisms.[95] The Food and Drug Administration (FDA) reported that in 1986, adverse drug reactions caused more than 1,300 deaths and over 4,400 hospitalizations.[96]

Analysts also differ about how much of medicine is of unambiguous value to patients. Some have estimated that as little as 15 percent to 20 percent of all contemporary clinical interventions are supported by objective scientific evidence that they do more good than harm.[97]

The validity of the evidence supporting various procedures has also come under question. The Office of Technology Assessment (OTA) has estimated that only 10 percent to 20 percent of medical practices are supported by randomized controlled trials.[98] A review of statistical methods in the published medical literature concluded that as many as half the articles that used statistical methods did so incorrectly. Another study found that the methodologies reported in 39 scientific papers on the use of percutaneous transluminal angioplasty were deficient for evaluating the procedure. None of the papers considered outcomes that patients might think important, such as relief from pain and continued ability to walk.[99]

Not all quality problems reflect overuse of service. Underuse is a quality problem as well. Some underuse reflects barriers to access. Underuse of services that is not due to direct access barriers may be classified as underdiagnosis or undertreatment.[100] Malpractice suits frequently allege that the physician or provider underdiagnosed or undertreated by missing a diagnosis or failing to follow-up on an abnormal test result.[101] Medicare Peer Review Organizations (PROs) include various screens for undertreatment in their quality reviews. For example, each PRO has to screen a sample of medical records to determine whether a patient was discharged prematurely or received an adequate discharge plan. These screens have detected few cases of underservice of Medicare patients, however. More prevalent, it would appear, are other types of underservice, such as less complete diagnostic services and fewer rehabilitation services than experts judge the elderly need.[102]

Bad medicine resulting from errors, negligence, incompetence or unprofessional behavior also jeopardizes the quality of care. Knowledge of such problems results from existing quality assurance mechanisms—such as Medicare Peer Review Organizations, the Joint Commission on Accreditation of Healthcare Organizations, utilization management entities that oversee the quality of care for the nation's larger employers, and inspections by state survey and certification teams.[103] Bad medicine can take many forms, including patients being discharged prematurely from hospitals; errors in diagnosis, medication, and treatment; faulty laboratory tests; hospital-induced infections and other complications resulting from medical treatment; and similar misadventures.

Malpractice Litigation: Protection or Problem?

Malpractice litigation provides consumers with a private course of action when they believe that the quality of the care required falls below acceptable standards.[104] At the level of the individual patient, poor quality medicine is often the catalyst leading to such a suit. But the evidence is strong that malpractice litigation does not adequately protect against or compensate for poor quality care.

A recent study of malpractice claims in New York showed that adverse events due to negligence occurred in 1.0 percent of all hospital discharges. Eight times as many patients suffered an injury from negligence as filed a malpractice claim, and 16 times as many patients suffered an injury from negligence as received compensation from the tort liability system.[105] This is consistent with evidence from the mid-1970s suggesting that at most one in 10 persons injured as a result of negligence actually filed a claim, and evidence from claims data of the early 1980s that one in five persons claiming negligence brought suit.[106, 107]

The same study also found that fewer than half the claims made by patients lead to payments by physicians or their insurers—suggesting that negligence did not occur.

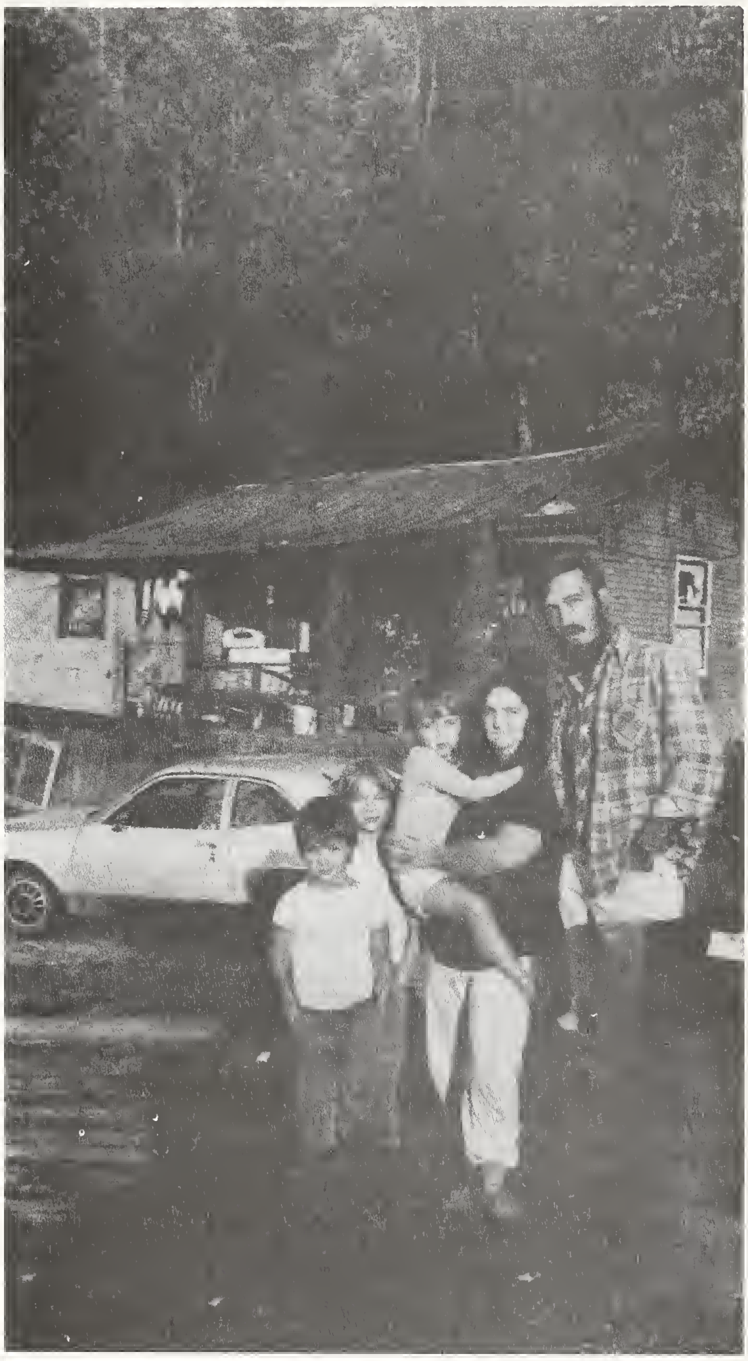
Not only does malpractice litigation provide limited protection; it creates cost, quality, and access problems of its own. The costs of malpractice premiums raise the costs of medical care. And the risk of litigation may distort physicians' practice patterns.

Total malpractice premium costs of doctors and hospitals were over $6 billion in 1987, about 2 percent of dollars spent on these services.[108] Professional liability premiums paid by self-employed physicians nationwide averaged $15,900. There is a great deal of variation in premium by specialty and by geographic location. Of the surveyed specialties, obstetricians/gynecologists averaged the highest premiums ($35,300), while psychiatrists averaged the lowest

($4,400). Annual premium rates for obstetricians and neurosurgeons in certain parts of the country exceed $100,000.[109]

Physicians' responses to the threat of malpractice litigation have been labeled defensive medicine, and can produce too much or too little care.

Defensive medicine increases care when a physician takes some action, whether necessary or not, to reduce the perceived risk of malpractice litigation—such as performing additional diagnostic tests, taking more time with patients to explain treatment options, and keeping more extensive medical records than necessary on any other grounds. Defensive medicine reduces care when the fear of malpractice litigation drives some physicians out of certain specialties and out of particular geographic locations. This problem is seen most sharply in studies of obstetrical services in low-income areas, where physician clinics are reducing this part of their practice, they say, due to the combined pressure of Medicaid cost containment and rising malpractice premiums.[110]



EARL DOTTER

In rural and urban communities without enough doctors, millions of Americans cannot get needed care.

A recent Institute of Medicine study concluded that, because of liability concerns, significant numbers of each of the physician groups examined were reducing obstetrical services to high-risk women, eliminating obstetrical practice altogether, or dropping it earlier in their careers than they otherwise would. Similarly, the American College of Obstetricians and Gynecologists (ACOG) in a 1987 survey of its membership found that its members were reducing or eliminating obstetrics as a result of the risk of malpractice.[111]

It is difficult to measure how much defensive medicine exists or how much it costs. By one estimate, about $11.7 billion out of the $82.8 billion paid to physicians in 1985 was attributable to service-increasing defensive medicine.[112] These numbers may overestimate the amount of potential harm, of course, because much of what might be labeled defensive medicine is good medical practice. But it is significant that a large portion of the medical profession believes that physicians have modified their practice patterns, and in some cases left the profession, in response to both malpractice premiums and their perception of the legal consequences of their medical decisions.

UNDERSERVED AREAS AND SPECIAL POPULATION GROUPS

The Commission's deliberations on health care focused chiefly on the financial barriers to access. But there is more to access than simply paying the bills. Even if health care were financed in full for everyone, some people would still have trouble obtaining adequate care for a variety of reasons—geographic, systemic, cultural, and personal. Like financial barriers to access, these nonfinancial barriers often result in people getting care later or less often than needed. As a result, their medical conditions become more severe and require more acute, and therefore more costly, treatment.

Nonfinancial barriers to access apply primarily to those living in medically underserved areas—such as rural communities or inner cities—and to members of population groups with special needs—such as the poor, substance abusers, the mentally or physically handicapped, and pregnant teenagers.

Medically Underserved Areas

Both rural and inner city areas have trouble recruiting or maintaining physicians and other health care professionals—in part because of the perceived undesirability of living or working in these areas, and in part because of the economics of maintaining a practice in places with large numbers of uninsured.[113] In 1988 there were 33 million people living in federally designated health manpower shortage areas (HMSAs). This population was about equally divided between urban and rural areas.[114]

Rural Areas—In 1985, there were 97.9 patient-care physicians per 100,000 population in rural counties, compared with 174.7 patient-care physicians per 100,000 population in urban counties. In rural counties with fewer than 10,000 population there were only 53 physicians per 100,000; and in counties with fewer than 2,500 residents there were only 29.9 per 100,000.[115] Although physician supply has increased recently in the more populated rural areas, it is expected to decline in the less populated areas due to a projected 25 percent rate of physician retirement in rural areas and severe cutbacks in the National Health Service Corps (NHSC) program, which supplies physicians to HMSAs. Even areas that can hold on to their physicians may be deprived of some essential services.[116] The problem of too few providers in rural areas is compounded by a general decline in the growth of primary care doctors, who are uniquely suited for rural practice and the shortage of nurses and other midlevel practitioners in rural areas.[117, 118]

Problems facing rural hospitals and health centers aggravate the situation. Low patient volume (because patients are so widely scattered in rural areas), Medicaid and Medicare reimbursement policies, rising numbers of patients unable to pay, and personnel shortages have forced an increasing number of rural hospitals to close their doors—all trends expected to continue.[119] Community and migrant health centers—important sources of primary care in some rural communities—have been facing increasing financial strains due to the failure of federal funding to keep pace with inflation, the increase in patients without insurance, rising malpractice premiums, and NHSC's cutbacks.[120]

Inner Cities—In 1988, 17 million residents lived in medically underserved urban areas—primarily inner cities. These areas are unattractive to many physicians and may not be able to support an economically viable medical practice.[121] The shortages are particularly acute for office-based primary care physicians. One study found that, between 1963 and 1980, the availability of such physicians declined in poverty areas, despite growth in the overall number of practicing patient care physicians.[122] This puts even greater burdens on the hospitals, which are beginning to close emergency rooms and trauma centers to avoid the increasing demand for uncompensated care. Finally, community health centers in urban underserved areas face the same financial and personnel strains as their rural counterparts.

Special Needs of Special Populations

Even those with the means to pay for care and providers to supply it may not have access to care for a variety of logistical, physical, mental, cultural, or personal reasons. The following are just a few examples of groups that face particular hurdles in obtaining care, although each of the barriers could apply to anyone.[123]

The Poor—Even if their health care is paid for, persons in poverty may face significant logistical barriers to care. For those who cannot afford to maintain a car, take public transportation, or pay taxicab fare, travel to medical care is a serious problem. When public transportation is available and affordable, the effort required to get from home to the source of care may be extraordinary.[124] Providers' limited office hours can pose another obstacle for the working poor who cannot take time away from their jobs.

Minorities—Minorities are more likely than average to be poor and thus to face the access barriers associated with poverty. They also face additional barriers arising from residence in the inner city, discrimination, and a variety of socioeconomic and cultural factors that make some individuals less disposed to seek necessary services even when those services are available.[125]

High-Risk Pregnant Women and Their Infants—An estimated one-third of all mothers receive insufficient prenatal care. Of these, the highest proportions are black, low-income, unmarried, or still children themselves.[126] Even those with insurance coverage may not obtain services because of child care or transportation problems, ignorance of the importance of prenatal care, or inability to find an acceptable provider.

The Geographically Isolated—Despite their access to transportation, people may have trouble getting to the source of health care in a timely manner if they are geographically isolated. Living in isolated areas also makes it more difficult to obtain home care and social support services, such as counseling.[127]

The Physically and Mentally Handicapped—The logistics of seeking health care can be particularly difficult for some groups. An escort or interpreter, or transportation accessible to the handicapped, may be unaffordable for low-income persons who are blind, deaf, or physically disabled, or may simply be unavailable in the community.

Mentally ill or retarded individuals may not have the skills necessary to negotiate the health system—such as making an appointment, arranging transportation, or getting a prescription filled. Some may not recognize their need for treatment. Those who do not have a friend or relative to assist them or urge them to seek care may go untreated, or may fail to comply with prescribed treatments.

Others—Other populations, and often their families, have special needs requiring multidisciplinary health care or social services to complement or augment their health care. These groups include the elderly, the homeless, HIV-positive individuals and persons with AIDS, other chronically ill persons, and substance abusers. For all these groups, social problems compound medical problems. Experience shows that medical care cannot be fully accessible and effective for such segments of the population unless it is accompanied by education and outreach, and by systems to coordinate a broad range of services.[128]

Current Programs to Address Delivery Barriers

From World War II through the 1970s, a major focus of federal health policy was to improve the availability of health services. The Hill-Burton program of hospital construction, support for medical education, and such programs as grants to community and migrant health centers all aimed to ensure that the best in American medicine would be available in every community. In recent years, federal support for these programs has diminished, partly because of budgetary constraints and partly because of a perception that—at least at the national level—we already have too many hospitals and too many doctors. Nevertheless, parts of the country still lag behind, and others are at risk of losing the resources they now have. Moreover, recognition is growing that many groups in the population need comprehensive care systems. Isolated doctors and hospitals do not suffice.

Some federal programs remain targeted at these needs. The various Public Health Service grant programs described earlier not only help finance care for the uninsured but also work to overcome provider shortages in underserved areas or to help fund outreach, social services, counseling, and service coordination. Programs to improve provider supply include the National Health Service Corps; the community and migrant health center programs; and funding for Area Health Education Centers, which decentralize medical training in the hopes of encouraging new providers to locate in rural areas. Programs that fund outreach and social services include the maternal and child health services block grant and various programs targeted at special groups, such as federally funded demonstrations of coordinated AIDS services networks.[129]

But the funding of most of these programs has failed to grow with the need and, for some, has shrunk during the last decade. The National Health Service Corps is a particularly dramatic example. The NHSC, which provides scholarships or loan repayments to medical students in return for service in underserved areas, has been cut back so dramatically that there were only 49 scholarship recipients in 1988, down from 6,409 in 1980.[130]

Federal cutbacks are being partially made up with state or local funds. States have been particularly active in developing special programs to reach pregnant women and coordinated care systems for other special populations, such as the mentally retarded and the mentally ill. Valuable as these activities are, however, they involve coordination of health resources already present in the community rather than new funds. Bringing new providers to communities that lack them, and providing the assistance needed to keep essential facilities in areas that can no longer support them, require greater financial resources than many states and localities possess.

Notes to Chapter 1

1. Unless otherwise noted, data for 1987 are from tabulations of the March 1988 Current Population Survey prepared for the Pepper Commission by John Sheils of Lewin/ICF, Inc.

2. U.S. Department of Commerce, Bureau of the Census, *Health Insurance Coverage 1986–88,* March 1990.

3. Discussion of the growth of the uninsured population draws upon U.S. Congress, House Committees on Education and Labor and Energy and Commerce and Senate Special Committee on Aging. *Health Insurance and the Uninsured: Background Data and Analysis,* report prepared by Congressional Research Service, 100th Cong., 2d Sess., 1988, Education and Labor Committee Print No. 100–2, 122–23. [Hereinafter cited as Education and Labor, *Health Insurance and the Uninsured.*]

4. Pamela J. Farley, "Who are the Uninsured?" *Milbank Memorial Fund Quarterly* 63 (Summer 1985): 476–503. This estimate is the proportion who face a 1 percent or greater risk of spending more than 10 percent of income. An estimated 7.9 percent of the under-65 population face a 5 percent or greater risk.

5. Jack Needleman, Judith Arnold, John Sheils and Lawrence S. Lewin, "The Health Care Financing System and the Uninsured," (Submitted to the Office of Research, Health Care Financing Administration, Department of Health and Human Service, April 4, 1990).

6. Farley, "Who Are the Uninsured?"

7. The following discussion relies chiefly on Education and Labor, *Health Insurance and the Uninsured,* 123–133. Similar data on plan provisions appeared in Steven DiCarlo and Jon Gabel, "Conventional Health Insurance: A Decade Later," *Health Care Financing Review* 10 (3) (Spring 1989): 77–89.

8. Small Business Administration, *The State of Small Business: A Report of the President* (Washington, D.C.: Government Printing Office. 1987).

9. Judith Feder, Marilyn Moon and William Scanlon, "Medicare Reform: Nibbling at Catastrophic Costs," *Health Affairs* 6 (4) (Winter 1987): 5–19.

10. Diane Rowland, "Fewer Resources, Greater Burdens: Medical Care Coverage for Low-Income Elderly People," in Pepper Commission, *A Call For Action,* Supplement to the Final Report (Washington, D.C.: Government Printing Office, 1990).

11. About 18 million people who do not get job-based or Medicaid coverage purchase non-group policies, the inadequacies of which are highlighted in the previous section. March 1988 Current Population Survey.

12. U.S. Department of Labor, Bureau of Labor Statistics, *Employer Benefits in Medium and Large Firms, 1988* (Washington, 1988).

13. Unpublished CRS analysis of March 1989 Current Population Survey.

14. Much of the following discussion is drawn from Education and Labor, *Health Insurance and the Uninsured.* See also General Accounting Office, *Health Insurance: Cost Increases Lead to Coverage Limitations and Cost Shifting* (Washington, D.C.: GAO/HRD 90–68, May 1990). [Hereinafter cited as GAO, *Health Insurance.*]

15. Mark Merlis, testimony before the Senate Committee on Labor and Human Resources, June 23, 1989.

16. U.S. Congress, House Committees on Education and Labor and Energy and Commerce and Senate Special Committee on Aging, *Costs and Effects of Extending Health Insurance Coverage,* report prepared by Congressional Research Service, 100th Congress, 2d Sess., 1988, Education and Labor Committee Print 100–EE, 46. [Hereinafter cited as Education and Labor, *Extending Coverage.*]

17. U.S. Congress, House Committee on Energy and Commerce, Subcommittee on Health and the Environment, *Medicaid Source Book: Background Data and Analysis,* report prepared by the Congressional Research Service, 100th Cong., 2d Sess., 1988, Committee Print 100–AA, 57–89. [Hereinafter cited as *Medicaid Source Book.*]

18. Melvina Ford, *Medicaid: FY 1991 Budget and Child Health Initiatives* (Washington, D.C.: Congressional Research Service, Issue Brief 90043, May 31, 1990).

19. U.S. Congress House Committee on Ways and Means, *Overview of Entitlement Programs: 1990 Green Book,* 101st Cong., 2d Sess., 1990, WMCP 100-293. [Hereinafter cited as the Green Book.] Most of the remainder will go for long-term care for the aged, physically disabled, and developmentally disabled.

20. Congressional Research Service, unpublished analysis of data from Current Population Survey (Washington, D.C., 1990).

21. For families with no pregnant women or children under 6 to which specific mandated eligibility levels apply. National Governors Association, *State Coverage of Pregnant Women and Children* (Washington, D.C., 1990).

22. Children's Defense Fund, *A Vision for American's Future* (Washington, D.C., 1989), 22.

23. Preliminary estimates by Congressional Research Service.

24. *Family Support Act of 1988,* P.L. 100-485.

25. *Medicaid Source Book,* 451-52.

26. National Governors' Association, *Increasing Provider Participation* (Washington, D.C., 1988).

27. John Holahan, Maureen Lewis and Marsha Silverberg, "Controlling Medicaid Costs in Hospitals," *Health Affairs* 7 (3) (Fall 1988).

28. *Medicaid Source Book,* 461.

29. See, for example, National Association of Children's Hospitals and Related Institutions, *Medicaid, Children and America's Future* (Alexandria, Va., 1989), 12-13.

30. Not included in this discussion are non-entitlement state and local programs such as funding for public hospitals and clinics, maternal and child health programs and prescription drug programs. See Needleman, et al., "Health Care Financing System and the Uninsured." Also not included are demonstration projects such as a limited state insurance program (WA) or subsidies for small employers. See Alpha Center, "Health Care for the Uninsured," *Program Update,* No. 10 (Washington, D.C., June 1990).

31. Intergovernmental Health Policy Project, *Recent State Initiatives for Covering the Uninsured* (Washington, D.C., 1989).

32. Health Care Financing Administration, *Analysis of State Medicaid Program Characteristics, 1986* (Baltimore, Md., 1987): 134. The total cited here differs from that reported in the original source, which erroneously included enrollees in one state's regular Medicaid program.

33. Robert L. Schiff, et al., "Transfers to a Public Hospital: A Prospective Study of 467 Patients," *New England Journal of Medicine* 314 (9) (February 27, 1986): 552-57.

34. Communicating for Agriculture, *Comprehensive Health Insurance for High Risk Individuals, A State by State Analysis* (Minneapolis, Minn., October 1988).

35. Ibid.

36. Robert Wood Johnson Foundation, *Access to Health Care Special Report No. 2* (Princeton, N.J., 1987).

37. Education and Labor, *Health Insurance and the Uninsured,* 137, 143, and 170-171.

38. Ibid., 134-148.

39. Robert Wood Johnson Foundation, *Access to Health Care.*

40. E.R. Greenberg, et al., "Social and Economic Factors in the Choice of Lung Cancer Treatment," *New England Journal of Medicine* (March 10, 1988): 612-617.

41. Joel Weissman and Arnold M. Epstein, "Case Mix and Resource Utilization by Uninsured Hospital Patients in the Boston Metropolitan Area," *Journal of the American Medical Association* 261 (24) (June 23/30, 1989): 3572-3576.

42. Robert Wood Johnson Foundation, *Access to Health Care.*

43. Education and Labor, *Health Insurance and the Uninsured,* 135-139.

44. John Billings and Nina Teicholz, "Uninsured Patients in District of Columbia Hospitals," *Health Affairs* (forthcoming).

45. American Cancer Society, *Cancer and the Poor: A Report to the Nation* (Washington, D.C., Spring 1989).

46. Ibid., 172. (Based on a Congressional Research Service analysis of the 1986 Health Interview Survey.)

47. Paula Broverman, et al., "Average Outcomes of Lack of Health Insurance Among Newborns in an Eight County Area of California, 1982–86" *New England Journal of Medicine* 321 (8) (August 24, 1989): 508–513.

48. Robert Wood Johnson Foundation, *Access to Health Care.*

49. National Commission to Prevent Infant Mortality, *Infant Mortality: Care For Our Children, Care For Our Future* (Washington, D.C., January 1988).

50. This discussion relies on Bonnie Lefkowitz and Judy Rodgers, "Primary Care Service Delivery Program—A Critical Element to Insuring Access to Care," in Pepper Commission, *A Call For Action,* Supplement to the Final Report (Washington, DC.: GPO, 1990). [Hereinafter cited as Lefkowitz and Rodgers, *Primary Care.*]

51. U.S. Public Health Service, Health Resources and Services Administration, *Justification of Appropriation Estimates for Committee on Appropriations, FY 1991* (Washington, D.C., Government Printing Office, 1989).

52. Compiled from: Department of Health and Human Services, FY 1991 Budget Tables, Department Press Release (Washington, D.C., January 29, 1990).

53. According to the Department of Health and Human Services, about 1,600 of the 7,000 hospitals in the United States have remaining free care obligations, most obligations expiring in the mid 1990s. Only about 50 hospitals have perpetual obligations.

54. Michael A. Dowell, "Hill-Burton: The Unfulfilled Promise," *Journal of Health Politics, Policy and Law* 12 (1) (Spring 1987): 153–75.57. 1990 Estimate, personal communication from U.S. Public Health Service, Health Resources and Services Administration.

55. Patricia A. Butler, *Too Poor to be Sick: Access to Medical Care for the Uninsured* (Washington, D.C. 1988).

56. Letter to the Commission from Thomas L. Joseph III, National Association of Counties, July 31, 1989.

57. Regional data on the proportion of inpatient services furnished by public hospitals are in American Hospital Association, *Hospital Statistics, 1988–89* (Chicago, 1989).

58. Unpublished estimates by the American Hospital Association, based on 1988 hospital panel survey data.

59. Public Health Foundation, *Public Health Agencies 1989: An Inventory of Programs and Block Grant Expenditures* (Washington, D.C., 1989).

60. James J. Mongan, M.D., executive director, Truman Medical Center, testimony before the House Committee on Ways and Means, Subcommittee on Health, April 4, 1990.

61. Prospective Payment Assessment Commission, *Medicare Prospective Payment and the American Health Care System: Report to Congress* (Washington, D.C., June 1989), 173.

62. Education and Labor, *Health Insurance and the Uninsured,* 148–155.

63. Ibid.

64. American Hospital Association, unpublished estimates based on hospital panel survey data.

65. Bruce C. Vladeck, President, United Hospital Fund of New York, testimony before the House Committee on Ways and Means, Subcommittee on Health, April 4, 1990.

66. Judith Feder, Jack Hadley, and Ross Mullner, "Falling through the Cracks: Poverty, Insurance Coverage, and Hospital Care for the Poor, 1980 and 1982," *Milbank Memorial Fund Quarterly,* 62 (4) (Fall 1984): 544–566.

67. Jack B. Franszek, M.D., testimony before the Senate Committee on Labor and Human Resources, July 25, 1989; Michael Specter, Emergency Rooms in Crisis," *Washington Post,* September 14, 1989, 1.

68. Health Care Financing Administration, Office of the Actuary, Data from the Office of National Cost Estimates, May 1990.

69. Health Care Financing Administration, Office of the Actuary, Division of National Cost Estimates, "National Health Expenditures, 1986–2000," *Health Care Financing Review* (Summer, 1987): 25.

70. Katherine R. Levit, Mark S. Freedland and Daniel R. Waldo, "Health Spending and Ability to Pay: Business, Individuals, and Government," *Health Care Financing Review* (Spring, 1989): 9.

71. Ibid.

72. "Health Plan Costs up 16.7% in 1989." *Business Insurance,* (Washington, D.C., January 26, 1990): 1.

73. Jon Gabel, Steven Dicarlo, Steen Fink and Gregory deLissovoy, "Employer-Sponsored Health Insurance in America," *Health Affairs* 9 (2) (Summer 1989): 116–128.

74. DiCarlo and Gabel, "Conventional Health Insurance."

75. GAO, *Health Insurance.*

76. DiCarlo and Gabel, "Conventional Health Insurance."

77. United States Department of Labor, Bureau of Labor Statistics, *News* (Washington, D.C., USDL 90–160, March 30, 1990).

78. W.J. Usery quoted in "Dole Names Panel to Study Coal Health Issues," *Associated Press,* March 8, 1990.

79. General Accounting Office, *Employee Benefits: Companies Retiree Health Liabilities. Large, Advance Funding Costly* (Washington, D.C.: GAO/HRD 89-51, June, 1989).

80. Health Care Financing Administration, Office of the Actuary, Data from the Office of National Cost Estimates, May 1990.

81. George J. Schieber and Jean-Pierre Poullier, "International Health Care Expenditure Trends: 1987," *Health Affairs* 8 (3) (Fall 1989): 169–177.

82. U.S. Public Health Service, National Center for Health Statistics, *Health United States: 1989* (Washington, D.C.: 1990).

83. Ibid.

84. Organization for Economic Co-operation and Development, OECD Social Policy Studies No. 4, *Financing and Delivery Health Care. A Comparative Analysis of OECD Countries* (Paris 1987), 46–47.

85. Colin McCord and Harold P. Freeman, "Excess Mortality in Harlem," *New England Journal of Medicine* 322 (3) (January 18, 1990): 173–177.

86. J.E. Wennberg, "Dealing with Medical Practice Variations: A Proposal for Action," *Health Affairs* 4 (2) (Summer 1984): 6–32.

87. John E., Wennberg, et al., "Are Hospital Services Rationed in New Haven or Over-Utilized in Boston?" *The Lancet* (May 23, 1987): 1185–1188.

88. John E. Wennberg et al., "Hospital Use and Mortality Among Medicare Beneficiaries in Boston and New Haven," *The New England Journal of Medicine,* 321 (17) (October 26, 1989): 1168–1173.

89. Lucian L. Leape, et al., "Relation between Surgeons' Practice Volumes and Geographic Variation in the Rate of Carotid Endarterectomy," *New England Journal of Medicine* 321 (10) (September 7, 1989): 653–657.

90. Robert H. Brook and Mary E. Vaiana, *Appropriateness of Care: A Chartbook* (Washington, D.C.: National Health Policy Forum, June 1989) and John E. Wennberg, "Dealing with Medical Practice Variations: A Proposal for Action," *Health Affairs* 3 (2) (Summer 1984): 6–31.

91. Institute of Medicine, *Medicare: A Strategy for Quality Assurance,* Vol. 1 (Washington, D.C.: National Academy Press, 1990); 45. [Hereinafter cited as Institute of Medicine, *Quality Assurance.*]

92. Brook and Vaiana, *Appropriateness of Care.*

93. Mark Chassin et al., "Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services?" *Journal of the American Medical Association* (November 13, 1987): 2533–2537. See also Brook and Vaiana, *Appropriateness of Care.*

94. General Accounting Office, *Improvements Needed in the Identification of Inappropriate Hos-*

pital Care (Washington, D.C.: GAO/PEMD-90-7, December 1989).

95. Institute of Medicine, *Quality Assurance,* 226.

96. U.S. Department of Health and Human Services, Food and Drug Administration, *Second Annual Adverse Drug/Biologic Reaction Report, 1986* (Washington, D.C., 1987).

97. Lynn Payer, *Medicine and Culture. Varieties of Treatment in the United States, England, West Germany and France* (New York: Henry Holt and Co., 1988 9-10) and Donald M. Berwick, "Health Services Research and Quality of Care. Assignment for the 1990s. *Medical Care* 27 (8) (August 1989): 764.

98. David Eddy, "Quality of Medical Evidence," *Health Affairs* (Spring 1988): 21-23.

99. Ibid.

100. Institute of Medicine, *Quality Assurance,* 224.

101. Ibid., 244.

102. Ibid., 144.

103. A recent survey of the findings of these various quality assurance mechanisms is provided in the Institute of Medicine, *Quality Assurance,* 230-249.

104. This summary is drawn from Paul Weiler and Troyen Brennan, "Medical Malpractice" in Pepper Commission, *A Call for Action,* Supplement to the Final Report (Washington, D.C.: Government Printing Office, 1990). [Hereinafter cited as Weiler and Brennan, "Medical Malpractice."]

105. Harvard Medical Practice Study to the State of New York, *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (Boston, 1990).

106. Patricia Danzon, "Medical Practice Liability," in *Liability-Perspectives and Policy,* ed. Robert E. Litan and Clifford Winston (Washington, D.C.: The Brookings Institution, April 1988), 105.

107. Patricia M. Danzon, *Medical Malpractice, Theory, Evidence, and Public Policy* (Cambridge, Mass.: Harvard University Press, 1985).

108. General Accounting Office, *Medical Malpractice: Framework for Action* (Washington, DC.: GAO/HRD 87-33, 1987) 2.

109. U.S. House Committee on Ways and Means, *Medical Malpractice,* 101st Cong., 2d Sess., 1990, WMCP: 101-26, Chapter 4.

110. Weiler and Brennan, "Medical Malpractice," and Dana Hughes, Sara Rosenbaum, David Smith and Cynthia Fader, "Obstetrical Care for Low-Income Women: The Effects of Medical Malpractice on Community Health Centers," in Institute of Medicine, *Medical Professional Liability and the Delivery of Obstetrical Care,* Vol. 2 (Washington, D.C.: National Academy Press, 1989), 59-78.

111. Institute of Medicine, *Medical Professional Liability and the Delivery of Obstetrical Care,* Vol. 1 (Washington, D.C.: National Academy Press, 1989).

112. Frank A. Sloan and Randall R. Bovjberg, "Medical Malpractice: Crises, Response and Effects," *Research Bulletin* (Washington, D.C.: Health Insurance Association of America, 1989): 25.

113. U.S. Congress, Senate Special Committee on Aging, *The Rural Health Care Challenge,* 100th Cong., 2d Sess., 1988, S.Rpt. 100-145, 51-53. [Hereinafter cited as Senate Aging Committee, *Rural Health Care Challenge.*] President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Securing Access to Health Care: The Ethical Implications of Differences in Availability of Health Services* Vol. 1 (Washington, D.C., 1983): 83-84. [Hereinafter cited as President's Ethics Commission Report.]

114. Designation as an HMSA is based on the ratio of residents to primary care providers and other factors indicating underservice. U.S. Public Health Service, Health Resources and Services Administration, Bureau of Health Care Delivery and Assistance, *The Bureau of Health Care Delivery and Assistance's Unique Role in Primary Care* (Rockville, Md., December 1988). [Hereinafter cited as PHS, *Bureau of Health Care Delivery and Assistance's Unique Role.*]

115. David A Kindig and Homoz Movassaghi, "The Adequacy of Physician Supply in Small Rural Counties," *Health Affairs* 8 (2) (Summer 1989): 66.

116. Senate Aging Committee, *Rural Health Care Challenge,* 52–53.

117. Department of Health and Human Services, National Health Service Corps, Office of Rural Health Policy, Discussion Paper, February 5, 1990.

118. Lefkowitz and Rodgers, "Primary Care."

119. Senate Aging Committee, *Rural Health Care Challenge,* 3–4, 9.

120. Ibid., 53.

121. President's Ethics Commission Report, 83–86.

122. David A. Kindig et al., "Trends in Physician Availability in 10 Urban Areas from 1963–1980," *Inquiry* 24 (2) (Summer 1987): 136–46.

123. Much of the following discussion is drawn from PHS, *Bureau of Health Care Delivery and Assistance's Unique Role.*

124. President's Ethics Commission Report, 85.

125. Ibid., 69–71, 110, 120, 190–193.

126. Alan Guttmacher Institute, *The Financing of Maternity Care in the United States* (New York 1987) 27.

127. President's Ethics Commission Report, 84–85.

128. Lefkowitz and Rodgers, "Primary Care."

129. U.S. Public Health Service, Health Resources and Services Administration, *FY 1991 Justification of Appropriation Estimates for Committee on Appropriations* (Washington, D.C., 1990), 124–26, 139–44.

130. Department of Health and Human Services, Health Resources and Services Administration, *Annual Report to Congress, National Health Service Corps,* 1989.

Chapter 2

Blueprint for Health Care Reform

Chapter 2

Blueprint for Health Care Reform

The Commission believes that federal action is urgent, not only because of the millions of Americans without adequate coverage, but because the current system of job-based and public health care coverage—which still provides adequate protection for most Americans—is falling apart. As health care costs continue to rise, the proportion of workers with job-based coverage will shrink. Small employers face increasingly formidable barriers in the private insurance market, and large employers are reducing benefits in efforts to limit costs. Public programs fail to cover millions now in need because of limited budgets and categorical restrictions on whom they may serve. And the demand for care is rising.

The Commission concludes that, in the absence of systemwide reform, the proportion of Americans without adequate health care coverage will grow, and the burden of caring for those who cannot pay will overwhelm the system, putting us all at risk of inadequate access to care. As costs continue to rise, more and more dollars will go to services of uncertain value, while millions of Americans will go without basic and necessary care.

To prevent such a disaster the Commission unanimously adopted the following goal:

> The Commission is committed to the development of recommendations for public policies that will assure all Americans access to health care coverage that allows them to obtain necessary care and assures them adequate financial protection.
>
> Regardless of the strategy the Commission chooses, coverage should:
>
> - Be affordable to Americans of all incomes;
> - Promote quality of care; and
> - Be supplemented or modified, where necessary (in "underserved" areas or for special population groups), by special programs to assure that service is accessible.
>
> The Commission is equally committed to reaching agreement on how to raise the financing required to assure access, through public or private means, and, in order to assure a realistic prospect of enactment, to structurally addressing the problem of health care costs while assuring access.

Before selecting its preferred course of action, the Commission explored two major alternative strategies to achieve this goal. (See Appendix B for a detailed discussion.) The first was an expansion of the Medicaid program to cover all the poor plus subsidies to help the near-poor purchase private health insurance. The Commission believes that such an approach would be an inadequate response to the crisis. Even the substantial expansion of public support that the Commission considered would leave an estimated 14 million Americans—about half the population now uninsured—without access to affordable coverage and would provide no help to additional millions whose coverage is inadequate. With so many still uninsured, cost shifting and the burden of uncompensated care would still mean inequity and instability in the system as a whole. Finally, broadening the public program for the poor but making no requirements on employers would allow employers who do not now provide coverage to continue to shift responsibility to others. That approach could also reduce employers' willingness to cover employees who are now protected, shifting substantial costs from employers to taxpayers.

The second major alternative the Commission considered was replacement of the current combined job-based and public approach with national health insurance. The Commission is convinced, however, that such a drastic departure from our current system would be controversial and disruptive to the majority of Americans for whom insurance still works, and would totally shift fiscal responsibility from employers to taxpayers. Furthermore, movement to a single federal system would eliminate diversity and choice that many believe, appropriately guided, would increase the strength and flexibility of our health care system.

In order to act now, as we must, the Commission recommends that we build upon and strengthen—not replace—the job-based and public coverage we now have into a universal system. This is, in the Commission's judgement, the most pragmatic strategy for securing adequate health care coverage for all Americans.

> **"Certainly I would agree . . . that [as a public policy, it's the government's responsibility to have accessible health care for every American]. The one thing I would add is that we see this as necessitating participation by all segments of our society."**
>
> **—Dr. Louis Sullivan, secretary,**
> **U.S. Department of Health and Human Services,**
> **responding to Representative Mary Rose Oakar**

With federal leadership to define the appropriate roles and responsibilities for employers and government in providing coverage, for private insurers and public programs in administering coverage, and for individuals in obtaining coverage, the Commission believes that mechanisms that now protect *most* Americans can guarantee coverage to *all* Americans.

Combining universal coverage with other federal initiatives to strengthen the health care system can also ensure value for the health dollar and access to quality service, efficiently delivered, that the nation so sorely needs.

SUMMARY OF RECOMMENDATIONS

The Commission's recommendations for health care reform have two parts: building universal coverage and strengthening the health care system.

Building Universal Coverage

The Commission's blueprint for building a universal job-based/public system of health care coverage has five parts.

1. The Commission believes that employers and the government together should provide a minimum level of health care coverage for workers and non-workers, who, in turn, should be expected to accept that coverage.

Small employers face considerable and increasing obstacles to purchasing affordable health insurance policies for their employees. Other Commission recommendations address the problems of the insurance market (see below). Because of these obstacles, and because it would take time for the insurance market recommendations to take effect, *the Commission recommends that small employers be encouraged through tax credits/subsidies to provide coverage for their employees.*

Large employers do not face such obstacles. *The Commission recommends that, after a period for adjustment, they be required to provide coverage for their employees.*

The subsidies and the insurance market reform should allow small employers to purchase affordable insurance for their workers. If sufficient progress has not been made after several years, *the Commission recommends that small employers become subject to the same requirements as large employers.*

> **"Japan has covered every single person [through a mixed public and job-based system]. And when I [asked] the Japanese Minister of Health, 'why don't you let the small businesses . . . drop insurance?' he said: 'Nobody in our political leadership would allow the Japanese to compete with the Americans by dropping insurance coverage.' "**
>
> **—Dr. Robert Blendon, professor and chairman,**
> **Department of Health Policy and Management,**
> **School of Public Health, Harvard University**

Even if job-based insurance becomes much more widely available, it will never be enough. The unemployed and the poor will need public protection. *The Commission recommends that the federal government provide coverage for these groups by replacing and expanding the role currently performed by states through the Medicaid program.*

When job-based coverage and the federal program are fully implemented and in place, *the Commission recommends that all individuals be required to obtain health care coverage from their employer or from the public program.*

2. The Commission believes that all parties—employers, individuals, and government—should share in financing health care coverage. Requirements for financial participation should not impose excessive burdens on individuals or employers. It is the federal government's responsibility to establish a ceiling on

obligations that is related to ability to pay, and to provide the additional financing, as necessary. *Therefore, the Commission recommends that the small employers encouraged to provide coverage receive tax credits/subsidies to reduce the costs of private insurance; that employers required to provide coverage be able to obtain it from a federal program for a contribution set at a fixed share of their payroll expenses; and that low-income workers and nonworkers receive subsidies to keep their contributions within reasonable bounds.*

3. The Commission believes that private insurers and government should each play a role in administering health care coverage. But there is a critical need for reforms to strengthen both private and public performance making coverage not only available but also adequate to ensure access to care. In order to preserve and expand private insurance as the primary source of job-based coverage, *the Commission recommends requirements that would bring an end to the underwriting, rating, and marketing practices that are unraveling private insurance protection for small employers.* At the same time *the Commission recommends that responsibility for providing public coverage be shifted from states to the federal government, severed from the welfare system, uniform across the country, and pay providers at rates determined by Medicare rules.*

4. The Commission believes that universal health care coverage that ensures people access to necessary care must meet an adequate minimum standard. That standard should establish basic protection for the currently uninsured and underinsured and preserve protection for the currently insured into the future. For public and private coverage, *the Commission recommends a federally specified minimum benefit package that includes preventive and primary care as well as other physician and hospital care.* Individuals would be responsible for a share of premiums and service costs—on all but preventive services—up to a maximum and subject to ability to pay.

5. The Commission believes that action cannot come too soon for the millions without coverage and millions more who see their coverage threatened. However, an effective system cannot be put into place overnight. It will take time to develop and implement.

To balance these concerns, *the Commission recommends that the system be put in place a step at a time.* The first and most critical step in expanding coverage is to ensure protection for pregnant women and children who are now uninsured and to initiate reforms that reverse the disintegration of the private insurance market for small employers. This would create an environment in which employers will have an opportunity to provide the coverage the Commission expects. The second step, to take place in years two through five of implementation, is to effect a series of incentives and requirements for employer coverage, giving employers time to adjust to their new obligations. The final step, to occur in year five, is to extend the federal government's coverage for all nonworkers.

The Commission believes this sequence of steps allows immediate action to address the most urgent problems and provides an orderly transition to universal health coverage.

Strengthening the Health Care System

The Commission recognizes that universal health care coverage can only be as sound as the health care system itself. Coverage that buys unnecessary or inappropriate care, that pays for poor quality, that fails to promote efficient delivery, or that shifts costs from some purchasers to others, wastes private and public dollars that could be used elsewhere.

The Commission disagrees strongly with the view that we cannot extend coverage to the uninsured until we control health care costs and reform the health care system.

The Commission believes, on the contrary, that expanding access to quality care and containing costs through increased efficiency are equally urgent and fundamentally intertwined goals. Ultimate success in reaching either goal can be achieved only through an integrated strategy of system reform. The Commission's recommended strategy has six parts.

1. The Commission believes the nation needs a national system of quality assurance aimed at defining appropriate or necessary services and ensuring that patients receive these services.

The Commission recommends that national practice guidelines and standards of care be developed and implemented; that a uniform data system on all health care services, regardless of payment source or setting, be developed and implemented to support research on treatment outcomes and assessment of provider performance; that new methods of quality assessment and assurance be developed and tested; and that local organizations be developed and held accountable for effective quality assurance.

It is also imperative that we find a better way to deal with the problem of malpractice. Because there is, at present, insufficient evidence to support specific reforms, *the Commission recommends that the Physician Payment Review Commission and congressional committees study and explore the issue of malpractice and propose legislative remedies.*

The Commission believes that universal coverage should be designed in a way that promotes efficiency in service use and delivery of care. Several of its recommendations pursue this goal.

2. *The Commission recommends a minimum benefit package that, except for preventive services, includes significant consumer cost sharing (subject to ability to pay and an out-of-pocket maximum) so that consumers recognize and are sensitive to costs as they consume services.*

3. The Commission recognizes the efforts of employers and their private insurers to manage their health care expenses by encouraging appropriate use of services and negotiating appropriate payment rates with providers. *Accordingly, its recommendations include managed care as an appropriate means of service delivery for employers as well as the federal government.* Insurers offering managed care to large employers would be required to extend that option to small employers as well. The Commission's recommendations for insurance reform, if implemented, would further encourage managed care and other cost management innovations because insurers could no longer profit simply by avoiding the "poor" risks. Competition would have to be based on efficient service and health care expenditures management.

4. *The Commission recommends also that the newly established federal program adopt and extend the Medicare program's increasingly effective payment mechanisms.* Initially for hospitals and more recently for physicians, Medicare's payment rules have been refined to reward providers for delivering services efficiently. Applying these rules in the new federal program would extend their scope for publicly financed patients as well as provide a model for private insurers seeking new ways to control their costs.

The Commission believes that its recommendations for universal coverage, if implemented, would end the inequities and inefficiencies in health care coverage that now impose excessive costs on some. Providing all Americans coverage and having all parties—employers, individuals, and governments—contribute their fair share of financing would dramatically reduce the cost shifting that now occurs from the uninsured to the insured population and from employers who do not provide insurance to those who do.

5. The Commission recognizes that universal coverage in an efficient health care system is necessary but not sufficient to ensure all persons access to the care they need. People in isolated rural areas and inner cities, and particular segments of the population—minorities and the poor, pregnant teenagers, the physically or mentally handicapped—would still face difficulties finding and getting the care they need. *The Commission recommends that expanded public coverage reinforce but not replace primary care delivery systems that are subsidized to serve these populations. It also recommends federal support to promote and extend systems that provide and coordinate a broad array of social and health services. Moreover, it recommends provider payment methods and other mechanisms to ensure general availability of health providers adequate to serve these most vulnerable citizens.*

6. The Commission's commitment to universal coverage in an efficient and effective health care system goes beyond ensuring access to treatment. Preventing the *need* for treatment ensures Americans the most secure and productive lives and uses the nation's resources most efficiently.

The Commission therefore recommends federal support for programs of health promotion, disease prevention, risk reduction, and health education toward the reduction of excess morbidity and mortality and toward the increase of healthy lifestyles.

Improving Protection for People 65 and Over

The above recommendations apply primarily to Americans under age 65. Nearly all elderly Americans receive their basic health insurance protection from Medicare. But gaps in Medicare protection expose the elderly to considerable financial risk.

To address these gaps in health care coverage for the elderly population, the Commission recommends three actions, consistent with recommendations for younger Americans.

1. The Commission is concerned that the elderly be protected against excessive financial burdens in obtaining health coverage or health care service. *The Commission therefore recommends that Medicare or the public plan that replaces Medicaid at the federal level provide assistance with the Medicare premium, deductibles, and cost sharing to all elderly people with incomes below 200 percent of poverty and undertake strong outreach efforts to ensure participation.*

2. Consistent with the insurance benefits provided to the under-65 population, *the Commission recommends that Medicare be expanded to provide selected preventive services. Preventive services to be added include mammography, colorectal, and prostate screening services.* As recommended for covering the under-65 population, other preventive services should be added when they are established as effective relative to costs.

3. Private insurance (usually termed Medigap) supplements Medicare for four out of five nonpoor elderly people. However, continued congressional oversight has documented that the Medigap market has historically been subject to considerable abuse and inadequacy.

The Commission recommends federal action to ensure the nonpoor elderly access to adequate coverage through insurance reforms that are generally consistent with reforms the Commission recommends for other health insurance plans. Action would include support for state or local counseling efforts and legislation to extend federal Medigap standards. Proposed standards would ensure policies of adequate value, allow consumers to compare policies and prices, and prevent sales abuses, duplication of coverage, and discrimination based on health status.

BUILDING UNIVERSAL COVERAGE

Building a system of universal coverage is the cornerstone of the Commission's strategy for solving the health care problems facing all Americans.

Structure for Coverage

The Commission's blueprint for universal coverage is based on the premise that all workers are entitled to a minimum level of health coverage through their own jobs, just as they are entitled to a decent minimum wage and to participation in Social Security. That means that all employers are expected to provide coverage to full- and part-time workers and their nonworking dependents.

The Commission believes that achieving job-based coverage for all workers requires separate strategies for large and small employers. Since most employers with more than 100 employees now provide adequate coverage for most of their employees, requiring such coverage imposes relatively modest changes in their current plans. Furthermore, they face no major barriers in obtaining private coverage. By contrast, many small employers do not offer coverage and face substantial difficulties in obtaining private health insurance.

The Commission recommends, therefore, that, after a period of adjustment, all firms with more than 100 employees be required to provide coverage to all their workers (and nonworking family members) by purchasing private insurance or by contributing toward their coverage through a newly established federal plan.[1] The contribution to the public plan would be set as a share of the employer's payroll. Employers would be able to purchase private coverage for their full-time workers and contribute to the public plan to cover their part-time workers.

The Commission recommends that employers with 100 employees or fewer be encouraged, through reforms in the insurance market and through tax credits/subsidies, to purchase private insurance for their workers. It is the Commission's hope that removing the major barriers to coverage and providing special help will enable small employers to cover most, if not all, of their workers. (As a target the Commission specifies that 80 percent of workers and their families now without health insurance from their employers be covered.) *If so, the Commission recommends that no requirements be placed on small businesses and that other mechanisms be found to cover the remaining uninsured workers.* (See discussion of phase-in for recommended actions.) *If voluntary mechanisms prove insufficient to ensure coverage in these firms, the Commission recommends that small businesses become subject to the same requirements as large businesses.* Assessments of coverage would be made after three years for firms with 25 to 100 employees, and after four years for firms with fewer than 25 employees to determine whether targets had been met.

The Commission recommends that nonworkers (including persons now covered by Medicaid) and the self-employed obtain coverage through the new federal plan set up for employers who wish to choose it for their workers. Self-employed individuals could choose coverage through this plan. The federal plan would provide the same minimum level of benefits as private insurance and would pay providers according to Medicare rules—the prospective payment system (PPS) for hospitals and the resource-based relative value scale (RBRVS), subject to volume performance standards, for physicians.

To ensure universal coverage, the Commission recommends that, when all elements of the coverage structure are fully in place, all individuals be required to obtain coverage either from their employers or from the federal plan. In imposing this requirement it is not the Commission's intent to deny care to individuals who fail to enroll, but to ensure that all individuals fulfill their responsibilities for contributing appropriately to financing universal coverage.

Sharing Financial Responsibilities

The Commission believes that employers, individuals, and government should share responsibility for financing health care coverage.

The Commission recommends that employers and employees share the costs of private insurance premiums or contributions to the public plan—paying at least 80 percent and no more than 20 percent, respectively. Individuals not covered through employment should pay a premium to obtain coverage in the public plan. Whether covered through the public or private plan, the minimum benefit package also requires that individuals contribute to the costs of services.

The Commission believes that the role of the federal government is to help employers and individuals meet these financial requirements when they exceed ability to pay. In this way, government guarantees that obtaining coverage, as a universal system requires, does not impose excessive burdens on any participant. Employers and low-income individuals both need help.

To help small employers the Commission recommends two kinds of tax credits/subsidies.

First, unincorporated businesses and the self-employed would be allowed to deduct the entire cost of their health insurance premiums for a plan that satisfies the minimum benefit standard. Currently, such employers can only deduct 25 percent of the cost of covering themselves and their families, while incorporated businesses can deduct the full cost. Furthermore, this 25 percent was a temporary provision included in the 1986 Tax Reform Act, scheduled to expire at the end of the 1989 tax year but extended until October 1990. After the expiration, unincorporated proprietors will be prohibited from deducting any of their insurance premiums.

Second, very small businesses employing low-wage workers would be entitled to a 40 percent subsidy against their portion of the cost of health insurance for the minimum benefits package. Specifically, employers with fewer than 25 employees and an average payroll of less than $18,000 per worker would be eligible for this subsidy for five years beginning with the second year the plan is implemented. This should help such firms afford health insurance and give them time to adjust for the increase in nonwage compensation in their business plans. The subsidy would go to small employers who already provide insurance, alleviating the burdens they face, as well as to employers newly insuring. After this period, firms with 10 or fewer employees who had received the credit and who faced extreme financial risk would have access to the public program at specially subsidized premiums.

The Commission recognizes that simply requiring employers to purchase private health insurance would impose a very uneven burden on employers, because employers with many low-wage employees would pay a much larger share of their payroll to comply than would employers with higher-wage employees. To prevent this inequity, *the Commission recommends that employers be allowed to buy either private or public health insurance and that public health insurance be available at a fixed percentage of payroll.* This would place a ceiling (cap) on employers' health insurance costs.

The contribution rate for the public insurance would be set at a level to encourage employers who now purchase private insurance to retain that coverage and to establish a fair balance of additional coverage responsibilities between the private and public sectors. The Commission believes that an appropriate rate should be based on circumstances at the time of implementation. Based on data currently available, the Commission estimates that a rate somewhere between 5.6 percent and 8 percent of payroll for the employer portion of the premium would achieve this goal (see discussion below). Since the contribution rate would be fixed as a percentage of payroll, no employer would have to pay more than this fixed percentage of the payroll to comply.[2] For cost estimating purposes only, this report uses 7 percent.

Setting the contribution at 7 percent means substantially lower coverage costs, relative to the costs of private insurance, for employers of low-wage or part-time workers. Based on currently available data, the employer's share of the specified benefit package in the private sector is estimated to cost on average about $1,000 per newly insured worker—about 50 cents per hour for a full-time worker, or $1.00 an hour for a person working 20 hours per week. For employers of minimum wage workers, obtaining the same benefits through the public plan at a cost of 7 percent of payroll would mean costs of less than 30 cents per hour for full-time workers and 7 percent of part-time workers' hourly wage. In essence this approach would protect employers of low-wage workers against the full costs of insurance while requiring them to contribute reasonable amounts.

It is important to understand that the payroll contribution is not designed to meet the full costs of public coverage. It sets a limit on the expenses of those employers with many low-wage employees, especially in high health cost areas. As a consequence, the cost of the public insurance plan for those employers who choose it would probably be more than the required contribution toward that cost. The shortfall would be federally financed.

To help low-income individuals, the Commission recommends subsidies that vary with people's incomes. Individuals whose income is under 100 percent of the federal poverty level would pay no premiums or cost sharing on covered services, whether covered by the public plan or private insurance. Individuals or families with incomes up to at least twice the poverty level would pay on a sliding scale—that is, a share of premiums and cost sharing that varies with their incomes.

Nonworkers or the self-employed who purchase coverage in the public plan at full actuarial costs would be eligible for similar subsidies. People with incomes below 100 percent of poverty (and pregnant women and children up to age six with incomes below 185 percent of poverty) would participate in the public plan at no cost and face no cost sharing requirements. People with incomes below at least 200 percent of poverty would pay up to 3 percent of income (1.0 percent if, as in the phase-in period, they are purchasing coverage for pregnant women or children only) for premiums. Other cost sharing would be on a sliding scale.

Adequate subsidization is critical to implementing the Commission's recommendation that all individuals be required to obtain coverage. Commitment to subsidize people up to *at least* twice the poverty level reflects the Commission's recognition that a more refined and extensive subsidy structure may be required to avoid undue financial burdens on low-income people. Further adjustments may be required to ensure that people who change jobs or move in and out of employment do not face annual cost sharing obligations (through the repeated application of deductibles) that substantially exceed levels specified in the minimum benefit package (described below).

Reforming the Private Health Insurance Market

The Commission believes that private insurance should be preserved and strengthened as the primary source of job-based coverage. Critical to achieving that end are reforms in the private health insurance market for small employers.

Within the small group health insurance market, the Commission recommends four changes to ensure all employers access to health insurance and to move toward making that insurance both predictable and affordable. Specifically, all insurers who wish to sell health insurance in the small group market would (a) be prohibited from applying preexisting condition exclusions; (b) have to guarantee acceptance of all small groups wishing to purchase health insurance; (c) have to set premium rates on the same terms to all groups within specified areas; and (d) be denied the opportunity to selectively increase rates for a particular group who had bought insurance.[3, 4]

Requirement (a) in conjunction with requirement (b) would ensure that all employer groups who seek health insurance would be able to find it. Requirement (c) in conjunction with requirement (d) would ensure that groups with a high-risk individual would not be priced out of the market.

A possible way to accomplish these goals would be to require that insurers in the small group market advertise an annual period (for example, January through March) during which they would accept all groups that wish to purchase health insurance from them. The insurer would be free to set the rate, but everyone seeking health insurance would be able to obtain coverage at the advertised price.

In implementing these reforms, the Commission is committed to eliminating practices that discriminate among purchasers on the basis of health status. The Commission did not decide, however, whether there would be a single price (a pure community rate) within each area or whether there would be different rates for different demographic groupings (a community rate adjusted by demographics).[5] For example, consistent with the recommendations, insurers might be allowed to set rates for broad age categories (under 30, 30 to 50, or older than 50, for instance) for men, women, and families based on the oldest household member.

A pure community rate establishes the broadest possible risk pool—sharing costs among young and old, males and females, and so on. Allowing age categories, however, would make insurance as inexpensive as possible to employers now without coverage, since uninsured workers tend to be disproportionately young.

The Commission recognizes that requiring either a pure or an adjusted community rate would compress the range of health insurance premiums toward the average cost of health care in the small group community, and that the initial impact would create "winners" and "losers" with respect to initial premium changes.

It is not clear whether such compression of health insurance premiums would result in relatively higher or lower average health insurance premiums over time. This would depend on the demographics of the uninsured in an area, how restricted the insurer is in setting different prices for different age or sex categories, and what proportion of the market is required to have health insurance coverage. In general, premiums would be lower the younger the uninsured, the more flexibility an insurer has in differentiating rates by age and sex, and the larger the proportion of the market required to have health insurance.

In the current health insurance market *all* small groups are increasingly at risk of having their health insurance premiums raised because of a change in health status of one individual associated with their group. By virtue of one or two individuals or their dependents, a relatively young and healthy group today may quickly become a less healthy group. The Commission's recommendations would remove this risk, which is growing even for low-risk groups in the current market.

The Commission recognizes, however, that reforms to spread risk would not reduce the average cost of health insurance premiums for many of those currently with health insurance. The Commission recommends four other reforms, therefore, to reduce the cost of health insurance for small groups.

Concern that small employers may not renew their coverage may lead insurers to include higher administrative costs in the first year's premium. *The Commission recommends allowing insurers to require minimum enrollment periods (for example, two years) so that insurers can spread out the costs of advertising and setting up a new group.* A minimum will also discourage costly movement that could occur with price competition in the new health insurance market.

State specification of benefits insurers must offer—referred to as state mandates—may also raise insurance costs above levels employers are willing to pay. *The Commission recommends that states be restricted from regulating the content of health insurance benefits. It recommends that state mandates be replaced with requirements that insurers offer a health insurance plan that meets the federal minimum benefits package and standardize additional benefits, to the extent possible.* It is not the Commission's intent, however, to replace state insurance legislation or authority with respect to fiduciary, consumer protection, or other standards by which states regulate health insurance.

Replacing state authority over benefits with a federal minimum standard could not only reduce the price of health insurance, but also would enable small-group employers to compare prices for the same level of coverage across different insurers. Standardizing health insurance benefits beyond the minimum benefit package—that is, having insurers use the same terms for the same benefit—would help employers to compare policies and to choose based on insurers' ability to manage their health care costs. Standardizing benefits, along with other reforms, would mean that insurers would have to compete on price and service rather than selecting the best risks.

The Commission also wants small businesses to benefit from the same potential cost savings through managed care as are available to large firms. *It recommends that insurers in the small group market be required to include small groups in managed care systems they offer larger employers.*

The Commission is also concerned about new costs that might accompany its requirement that insurers accept all risks. *The Commission recommends a reinsurance mechanism to allow an insurer to contract with other insurers for excess risk.* Under this arrangement, an insurer would purchase a contract with another company (usually an insurer or a reinsurer) that would pay all health care costs above a specific threshold. The reinsurance mechanism would organize this market for insurance companies that do not have access to a private reinsurance market.

Creating the Federal Public Program

The Commission is concerned that a public program be attractive to those employers who find it the most affordable means of protection, that it guarantee covered workers and nonworkers the same benefits and access to health care established as a minimum standard for private insurance, and that it pay providers adequate rates.

The Commission recommends that the current federal/state Medicaid program for covered services be replaced with a new federal entitlement program that would guarantee all persons similar protection, no matter where they live.

States would be required to contribute to the new program amounts they now spend through Medicaid on the services and population the new program would cover. Contributions would be increased annually to reflect general, not health care, inflation.

Although the Commission does not assign administrative responsibility for the new program to the Medicare program, operation in conjunction with or as part of that program is consistent with the Commission's intent. The Commission would allow the new public plan, like Medicare, to rely on private insurers to administer claims and, under contracts, to offer managed care options. It would further allow states to administer the new public plan, at their option and subject to federal rules. Federal rules would ensure administration consistent with the Commission's intent that the program guarantee coverage for specified benefits to all persons not covered through employment and payment to providers at federally specified rates.

To reflect the Commission's commitment to severing the tie between welfare and public health insurance coverage, *the Commission recommends that all aspects of any state administration be conducted through an agency which is unconnected to the state's welfare or Medicaid departments.* Although the Commission does not formally address further aspects of administration, its commitment to universal coverage and its cost estimates imply that the new public program would be administered to ensure participation by all persons eligible.

The Commission recommends that the new program pay providers Medicare rates, as appropriate, or, more broadly, rates determined according to Medicare rules (including the prospective payment system for hospitals and the new resource-based relative value scale, subject to volume performance standards and limits on balance billing, for physicians' services.) [6] This approach reflects the Commission's intent that public programs for low-income people and others (a) pay appropriately for service, both to ensure access for the population served and to avoid shifting costs to the privately insured; and (b) contain cost increases over time (as discussed below).

Benefits for workers and nonworkers would be similar. The main exception is that the public plan would include early, periodic screening, diagnosis, and treatment services (EPSDT) for children, consistent with coverage under the current Medicaid program. Workers whose employers choose coverage through the public plan would also receive these benefits. Privately insured workers could obtain the coverage of these services through the public plan at cost (or at a rate, subsidized as above, for families with incomes under at least twice the poverty level).

Minimum Benefit Package

The Commission believes that universal coverage for health care that ensures people access to necessary care requires establishing a minimum standard for coverage. That standard would establish basic protection for the currently uninsured and underinsured and would preserve protection for the currently insured into the future. *The Commission recommends that a federally specified standard benefit package supersede current state laws requiring insurers to offer specific benefits; that employer-based coverage through traditional or managed care plans provide at least the minimum standard* (although employers are not precluded from offering more generous plans, as most do now); *and that the same minimum package (with modest modifications) be provided to nonworkers and others through the public plan.* [7]

The recommended minimum benefit package covers:

- Hospital care, surgical and other inpatient physicians' services, physician office visits, diagnostic tests, and limited mental health services (45 inpatient days and 25 outpatient visits).[8, 9]
- Preventive services, including prenatal care, well-child care, mammograms, pap smears, colorectal and prostate cancer screening procedures and other preventive services that evidence shows are effective relative to costs.[10, 11] (One year after the effective date of the Commission plan, the Office of Technology Assessment shall report to the Secretary of Health and Human Services on an assessment of the cost-effectiveness of prescription drug coverage for inclusion as a preventive service.)

Individuals would be required to contribute to the costs of coverage as follows:

- Individuals covered through employment pay a maximum of 20 percent of the premium for private coverage or a contribution to the public plan equivalent to 20 percent of the combined employer-employee contribution and paid as a percentage of wages.
- Individuals not covered through employment pay the full costs of coverage in the public plan, subject to ability to pay.
- Cost sharing for basic services includes a deductible of $250 for an individual and $500 for a family. For all services except mental health outpatient services and preventive care services, individuals pay 20 percent coinsurance. Outpatient mental health services are subject to 50 percent copayment. There are no deductibles or coinsurance on preventive services.

- Once individuals' or families' cost sharing for covered services reaches $3,000, individuals make no further out-of-pocket payments for covered services.
- Premiums and cost sharing requirements are subsidized for low-income people. People with incomes below 100 percent of the federal poverty level pay no premiums or coinsurance. Premiums and cost sharing are also subsidized, on a sliding scale, for people with incomes up to at least 200 percent of poverty. For this population, premiums may not exceed 3 percent of income.

This package responds to a number of the Commission's concerns.

Parity with Employer Coverage—A job-based approach to universal coverage would impose requirements on employers to cover employees not now covered. The Commission aims to provide coverage similar to, but somewhat less generous than, most employers who provide coverage now offer.

The 20 percent maximum on employee contributions to premiums is less generous than the practices of most employers (see Table 2–1). In 1987, the majority of all firms required less than 20 percent payment from employees toward premiums for single and family coverage.

Table 2–2 compares the Commission's package to benefits provided by employers. With the exception of preventive services, most employers with coverage provide the benefits recommended in the minimum package. Most employers also provide prescription drug coverage, which at the outset is not included in the Commission's package. (See discussion of preventive services.) About 70 percent of employers who currently offer insurance provide benefits that are at least actuarially equivalent to the recommended minimum package.[12]

Table 2–1 Percentage of Firms Paying More Than 80 Percent of Employee Health Premiums

Type of Policy	Number of Employees in Firm					
	<25	25–99	100–499	500–999	1,000+	All
For single coverage.......	63%	65%	71%	72%	70%	68%
For family coverage.......	60%	44%	62%	62%	61%	59%

SOURCE: Shiela Zedlewski, analysis of March 1988 Current Population Survey, using the Urban Institute's Transfer Income Model (TRIM2), the Urban Institute, January 1990.

Table 2–2 Benefits: Commission Plan Compared with Current Employer Practices

Benefits	Commission Plan	SBA (All Firm Sizes)	Hay/Huggins (Medium and Large Firms)
Hospital services............	Yes	100%	100%
Surgical services............	Yes	100%	100%
Physician office visits.....	Yes	83%	99%
X-ray and lab..................	Yes	99%	99%
Prescription drugs..........	No	87%	98%
Inpatient mental health..	Yes	82%	98–100%
Outpatient mental health.	Yes	82%	99%
Dental..............................	No	33%	90%
Colorectal and prostate cancer screening, mammograms, and pap smears.	Yes	N/A	N/A
Routine physical/ preventive exams.	No	N/A	64%
Well-child care (includes routine exams, tests, and immunizations).	Yes	N/A	Not covered

N/A=not available.

SOURCE: Pepper Commission staff analysis based on Small Business Administration, *The State of Small Business: A Report of the President,* 1987, Washington D.C., U.S. GPO and Hay/Huggins Benefits Report, *1989 Prevalence of Practice and Executive Summary,* Hay Group, 1989.

Finally, the Commission's recommended cost sharing requirements and its $3,000 cap on out-of-pocket spending are more extensive than job-based plans typically require, except that they eliminate cost sharing for preventive services (see Table 2–3).

Universal Standard Appropriate to Needs of the Uninsured—The Commission is concerned that the minimum benefit package be both a minimum standard for all Americans and appropriate to the needs of the uninsured, who are disproportionately low income. Primary care services are critical to the uninsured because, without coverage, these services are particularly difficult to obtain. Coverage of primary care reduces financial barriers that lead to inappropriate use of high-cost providers and delays in seeking care. Hospital coverage is standard practice and essential to ensure protection against financial catastrophe and to avoid shifting costs from some patients to others.

Cost Sharing Requirements—The deductibles and the hospital coinsurance in the package are higher than in typical plans provided by firms now offering health insurance. The Commission believes that individuals should share in the responsibility of paying for health services and that cost sharing makes the consumer more cost conscious when purchasing care. But the Commission intends that cost sharing should not become a barrier to health care for people who could not afford it. For people with low incomes even small contributions can be a barrier to necessary care. Therefore, as described above, the Commission recommends that low-income people whose income is up to *at least* 200 percent of poverty be provided with subsidies for premiums, deductibles, and coinsurance requirements. There is some evidence that a family's income must be 250 percent of poverty before discretionary income is available to spend on health care.[13]

The Commission also recognizes that cost sharing with no limits can impose catastrophic expenses even on people with higher incomes. Its minimum benefit package includes a catastrophic cap to protect everyone from expenses above that amount.

Table 2-3 Cost Sharing: Commission Plan Compared with Current Employer Practices

Benefits	Commission Plan	Typical (Medium and Large Firms)
Deductible—single/family	$250/500	$100/300
Out-of-pocket limit—single/family	$3,000/3,000	$1,000/2,000
Hospital services	20%	0
Surgical services	20%	20%
Physician services	20%	20%
X-ray and lab	20%	20%
Mental health		
Inpatient	45 days/20%	30 days/20%
Outpatient	25 visits/50%	50 visits/ 50%
Prenatal care	0	20%
Mammogram, pap smears, colorectal, and prostate cancer screening.	0	N/A
Well-child care	0	Not covered

N/A=not available.

SOURCE: Pepper Commission staff analysis based on CRS report, *Design of Health Plan Benefits for the Nonelderly,* October 24, 1989.

Preventive Services—The Commission believes that preventive services are critical to adequate coverage. Preventive services have historically been excluded from insurance policies because their use does not meet the traditional definition of an insurable event. Nevertheless, recent surveys indicate that coverage of preventive services in health insurance plans may be increasing.[14] The Commission believes the specific preventive benefits included and the commitment to include others—as they are demonstrated to be cost-effective—will prevent or delay the onset of disease and detect illness early enough for effective treatment. This could result in reduced mortality and improved quality of life, and could also produce savings by averting the costs of expensive treatments.

Because cost sharing is associated with reduced use of service, and because the Commission believes that the use of preventive services should be encouraged, deductibles and coinsurance would not apply to these services.

Role of Medicaid—The public plan would replace the mandatory Medicaid package. The Commission intends that current Medicaid beneficiaries would not be made worse off by the creation of the new public program. Many states currently offer a variety of optional services including prescription drugs (provided in all states), dental services, and optional mental health services to their Medicaid populations.[15] *The Commission recommends that a residual Medicaid program be maintained which provides these benefits to Medicaid beneficiaries at current federal/state matching rates.*

Putting Universal Coverage into Effect

The Commission recognizes both the urgency of ensuring universal health care coverage and the time and planning needed to make universal coverage effective and avoid undue disruption. It recommends implementation in five phases, each lasting a year. The phases are sequenced so that the most urgent problems and reforms needed to make the system work are dealt with first.

Year One—The Commission believes that the nation cannot afford to delay adequate protection for pregnant women and children. *The Commission recommends that universal coverage begin by ensuring that all uninsured pregnant women and children up to age six in nonworking families or families of workers whose employers do not provide health insurance can enroll in the new federal public plan.* That plan would also absorb pregnant women and children now served by the Medicaid program. Reimbursement rates would be improved, relative to current Medicaid rates, based on Medicare payment principles.

This step would not only provide critical coverage; it would also begin to build the new federal program that is a major component of the universal system.

At the same time, the Commission recommends that the reforms needed to build the private insurance component of that system—reforms of the private insurance market—be initiated. This step would ensure access to health insurance by all employers, regardless of industry, size, or age or health status of their work force.

Year Two—In the second year *the Commission recommends extending access to the federal program (and replacing Medicaid) for children to age 18, and providing the subsidies to small employers (and, for premium shares and cost sharing, to their low-income employees) to facilitate the purchase of private health insurance in the reformed marketplace.*

Specifically, unincorporated businesses would be allowed to deduct the full cost of health insurance from taxable income. As a way of further easing what may be a difficult transition, firms with fewer than 25 employees and average payrolls below $18,000 per worker (whether or not they now offer insurance) would receive a 40 percent refundable tax credit toward the purchase of coverage that satisfies the minimum benefit standard. Firms could make use of this credit during the five-year period following its first availability. After the credit ends, firms that are at extreme financial risk and that employ 10 or fewer workers could purchase coverage from the public plan at an affordable rate.

Also in year two, reimbursement rates in the new federal plan would be set according to Medicare principles, as would rates for adults remaining in the Medicaid program.

Year Three—When firms have had two years to plan and adjust, *the Commission recommends that all firms with more than 100 employees be required to provide health insurance coverage to their employees (full- and part-time) and their nonworking family members,* by purchasing private coverage or contributing to the public plan on their workers' behalf.

Year Four—By the fourth year of the program, the Commission believes it would be necessary to assess the adequacy of efforts to ensure universal coverage for employees and their families in businesses with 25 to 100 workers. At enactment, the number of workers and dependents without health insurance from their employers who are attached to firms of less than 100 employees would be estimated. In year four, *the Commission recommends that it be determined whether 80 percent of workers and dependents in firms with 25 to 100 employees who lacked coverage from their employers at the outset had obtained it.*

Current data indicate that about 6 million workers are employed by firms with 25 to 100 employees but are either without any health insurance or obtained coverage from a source other than their own employer.[16] These data indicate that the coverage target for year four unadjusted for changes in the target employer population would be 4.8 million workers (80 percent of 6 million) plus their dependents not previously insured by their employers.

The Commission recommends that the Secretary of Health and Human Services be required to determine whether the target has been met.

If the coverage target has been met, the Secretary would then be required to report to Congress on how to ensure that workers in these small firms who remained uninsured could be provided coverage.

The Commission intends that this process leave no one without coverage. To guard against gaps, *the Commission recommends that Congress provide expedited procedures under which to consider the Secretary's recommendations.*

The Commission also intends that the Secretary continue to monitor the insurance status of this group and report periodically on it to Congress, to ensure that the combination of mechanisms still provides universal coverage.

If the Secretary finds that the target has not been met, employers with 25 to 100 employees would become subject to the same requirements as larger firms.

Year Five—In the fifth year of the program, *the Commission recommends that the Secretary assess the adequacy of coverage in firms with fewer than 25 workers.* Calculations on coverage, determinations by the Secretary, and action by Congress would occur as specified above. Current data indicate that about 23 million workers in firms with fewer than 25 employees now lack protection from their employers. These data indicate a coverage target of 17.6 million workers plus their dependents.

If the coverage target has been met, the Secretary would recommend to Congress ways to ensure coverage for persons still without it. The same safeguards to ensure universal coverage, initially and over time, would also apply to this group of firms. If the 80 percent target has not been met, employers with fewer than 25 employees would become subject to the requirements imposed on firms with more than 100 workers.

The Commission's intent is to ensure that special attention be given to coverage for domestic workers and others in nontraditional employment roles. The Commission suggests that the Secretary of Labor be required to report to Congress 12 months after the fifth year of implementation on whether employers of these workers are providing health insurance. Consideration could be given to special measures to encourage coverage during the voluntary phase and to ensure their participation if requirements go into effect. Enforcement for these employers might require special penalties for noncompliance, possibly including employer liability for employee medical expenses.

Also in year five, *the Commission recommends that all individuals not connected to the workplace and all individuals still covered by Medicaid become eligible for participation in the federal public plan.*

If small employers do not reach their coverage targets, thus triggering coverage requirements for *all* employers, the combination of job-based and public coverage would be fully in place.

At the end of the fifth year, in that case, all individuals would be required to have health insurance through their employer or through the public plan.

If one or both of the classes of small employers meets its target, but some workers still are not covered, the Congress should act on the Secretary's recommendations for covering this group. Such action should precede requirements that all individuals have coverage.

The special subsidies/tax credits for small firms with low-wage employees would expire within five years of their availability. An exception would be made, however, for firms that face extreme financial risk and that employ 10 or fewer people (see Table 2–4).

Costs, Coverage, and Service Impacts of Commission's Recommendations

Building universal coverage in the way the Commission recommends would extend coverage to the more than 31.5 million Americans who are now uninsured. It would also ensure adequate health insurance coverage for the roughly 20 million Americans who have some insurance but are still exposed to catastrophic costs in the event of major illness. All Americans would benefit from the guarantee of basic protection.

Inevitably, additional coverage costs money, even though the Commission's proposed structure includes reforms to promote efficiency and control health care costs. But in fact the Commission's recommendations would buy health coverage for all Americans for less than 2 percent more than health care expenditures under current law. The projected increase in total health care expenditures would amount to $12.0 billion in 1990, increasing total current health care expenditures from $647 billion to $659 billion in 1990 (see Table 2–5). (All cost estimates in the discussion that follows are for 1990.) [17]

Not all sectors of society would be required to pay more, however. Employers who now offer health insurance to workers and their dependents are projected to save about $13 billion a year, because they would no longer bear the cost-shift of covering (as dependents) individuals who work for other firms and of uncompensated care or low Medicaid payments. Individuals and families are projected to save about $19 billion a year, as employers and government share in their insurance premiums and health care costs. State and local governments are projected to save $7.4 billion a year in payments for the uninsured. Because their health care expenditures would be limited in real terms to their current Medicaid contribution, states would also be relieved of the growing burden for the medically indigent.

Employers who do not now provide health insurance for their workers and the federal government would share the costs of the additional coverage. The newly insuring employers would incur a total of $27.5 billion a year in increased payroll costs—an average of less than 4 percent of payroll (after taxes). For a single employer the increase could not exceed a specified percentage of payroll (7 percent, in this analysis, based on current data). This is because the Commission's recommendation to set up a public health insurance program would effectively cap an employer's risk. The additional cost of guaranteeing universal coverage, $24 billion, would be financed by the federal government. (For alternative ways to fund this increase, see Chapter 5 and Appendix F.) Table 2–4 shows how costs would be phased in.

Costs to Employers—The net additional cost projected for employers under the Commission's recommendations would be made up of several different components (see Table 2–6). Under current arrangements, employers who now provide health insurance are expected to pay out $125.3 billion in 1990. Under the Commission's recommendations their bill would be reduced by $12.8 billion, 10.2 percent lower than their projected health care costs. Reduced premium expenses for working spouses and other dependents (who would be covered by another employer) would save employers $19.2 billion. An end to uncompensated care and related cost shifting would save them another $9.5 billion; and the cap on liabilities another $1.5 billion. This saving would be partially offset, however, by the cost of additional premiums to cover part-time workers and their dependents ($4.8 billion), the cost of meeting the minimum benefit and premium standards ($9.3 billion), and $3.3 billion in increased tax liabilities, as tax-favored health expenditures decline.

Table 2-4 Phase-In Schedule and Cost of the Commission's Health Care Proposals

(1990 Dollars) [a]

Year 1

Insurance reforms are initiated.
All uninsured pregnant women and children to age 6 are allowed to enroll in the public plan (with low-income subsidies), and current Medicaid recipients in those categories are transferred to the public plan.
Reimbursement rates are improved relative to Medicaid rates.

New federal cost	$3.4 billion
Percent of Americans without health insurance	14%

Year 2

Firms with fewer than 25 employees and average payrolls below $18,000 become eligible to receive a 40 percent tax credit/subsidy for the cost of health insurance that is provided. Employees of these firms with low family income receive a subsidy.
Public plan is available to uninsured children up to age 18, with low-income subsidies.
Public plan's and Medicaid's reimbursement rates are improved in accordance with Medicare principles.

Additional federal cost from Year 1	$13.5–16.8 billion [b]
Cumulative new federal cost, Years 1–2	$16.9–20.2 billion [b]
Percent of Americans without health insurance	8–11% [b]

Year 3

Firms with more than 100 employees are required to provide health insurance or contribute a portion of payroll to cover employees and dependents in the public plan.

Additional federal cost from Year 2	$ 4.6 billion
Cumulative new federal cost, Years 1–3	$19.5–22.8 billion [b]
Percent of Americans without health insurance	6–8% [b]

Year 4

If 80 percent of uninsured employees of firms with 25 to 100 employees (as of Year 1) are not insured through their employers, along with their dependents, all employers of this size are required to provide coverage or contribute to the public plan.

Additional federal cost from Year 3	$ 0.8 billion
Cumulative new federal cost, Years 1–4	$20.3–23.6 billion [b]
Percent of Americans without health insurance	5–7% [b]

Year 5

If 80 percent of uninsured employees of firms with fewer than 25 employees (as of Year 1) are not insured through their employers, along with their dependents, all employers of this size are required to provide coverage or contribute to the public plan.
Allow all uninsured adults into the public plan.

Additional federal cost from Year 4	$3.8–7.1 billion
Cumulative New Federal Cost, Years 1–5	**$ 27.4 billion** [c]
Percent of Americans Without Health Insurance	**0** [d]

[a] Cost estimates are presented as if each phase were fully implemented in 1990. Costs are not adjusted to reflect inflation or cost containment savings.

[b] Actual number depends on how many smaller firms voluntarily choose to purchase health insurance.

[c] New federal costs in Year 5 are greater than the full implementation costs of $24 billion. This is because of the additional subsidies to smaller employers *during* the phase-in period. Except for firms of 10 or fewer employees at extreme financial risk, these additional subsidies end not more than two years after Year 5.

[d] If the coverage targets are met voluntarily, the Secretary of Health and Human Services must submit to Congress a plan to insure any remaining uninsured. At that point (or in Year 5, if coverage targets are *not* met voluntarily), all individuals are required to have either private or public plan coverage.

Table 2-5 Impact of Commission Plan on Health Care Spending, by Source

(In Billions, 1990)

Federal spending		$24.0
State and local spending		(7.4)
Employer spending (after taxes)		14.7
Employers who now insure	(12.8)	
Employers who do not now insure	27.5	
Household expenditures		(19.3)
Net new spending		$12.0

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model.

Employers who do not now provide health insurance coverage for their workers would be required to share the cost of the new coverage (see Table 2–7). Currently, of course, they pay nothing. The Commission's recommendations would require them to pay net costs of $27.5 billion. There would be $23.5 billion in private premium payments and $12.9 billion in employer contributions to the public plan. But this $36.4 billion bill would be partially offset by $8.9 billion in reduced tax liability, as tax-favored health expenditures increase. Total new costs, after taxes, amount to less than 4 percent of payroll. (The costs for small versus large employers are shown in Appendix C.)

Impact on Employment—These costs to employers represent the short run impact of the Commission's recommendations. Over the longer run, costs attributed to employers fall on three groups: employers, employees, and consumers.

Economists typically assume that required employer expenditures are borne by workers, in reduced wages. Wage reductions, however, are not possible for workers at or near the minimum wage. For these workers, the cost would be reduced employment. These reductions could come in layoffs, slower rates of employment growth, or failure to replace workers who leave their jobs.

The degree of reduced employment stemming from expanded job-based insurance depends on the number of minimum and near-minimum wage workers affected, as well as the increased costs of providing insurance. With a cap on employer contributions set at 7 percent of payroll, the hourly wage of minimum wage workers would increase by approximately 27 cents per hour. Under the recommendations, nearly 10 million workers working at or near the minimum wage ($4.25 per hour) would be affected. Recent surveys of the minimum wage literature indicate that each 10 percent increase in the minimum wage reduces employment by anywhere from 0.5 to 3 percent.[18] This research indicates the effect on adults is in the lower range. These estimates indicate that 25,000 to 50,000 low-income workers could be displaced by the coverage requirements—a number that is small enough to be offset by job creation through the normal workings of the economy. According to the Bureau of Labor Statistics, 39,000 jobs were created in June 1990. Over six million jobs were created over the previous three year period.

Costs to Individuals—When the Commission refers to costs for individuals it means workers' shares of job-related premiums, premium payments for

Table 2-6 Impact of Commission Plan on Employers Who Now Provide Health Insurance

(In Billions, 1990)

		Employer Costs
Current employer expenditures for health insurance costs		$125.3
Changes in employer costs under Commission Plan:		
Cost of insuring part-time workers and dependents		4.8
Impact of minimum benefit and premium standards		9.3
Employer premium share increase	6.6	
Improvement in plan provisions	2.7	
Working spouses and dependents shifted to other employer plans		(19.2)
7.0 percent cap on employer costs		(1.5)
Cost-shift savings		(9.5)
Total employer costs		$109.2
Net change in employer costs		(16.1)
Change in tax expenditure		3.3
Net after-tax change in employer costs		(12.8)
Percent change in employer health insurance costs		(10.2%)

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model.

Table 2-7 Impact of Commission Plan on Employers Who Do Not Provide Health Insurance

(In Billions, 1990)

	New Employer Costs
Employer premium payments to private insurance	$23.5
Employer contributions to public plan	12.9
Total employer cost	36.4
Change in tax expenditure	(8.9)
Net after-tax change in employer costs	$27.5
Change in employer costs as a percent of payroll	3.6%

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model.

nongroup plans, and out-of-pocket payments by individuals (see Table 2-8). Under the Commission recommendations, individuals would save $19.3 billion. Expanded employer and public coverage would save individuals who now buy insurance $16.3 billion in premium payments—$5.7 billion for job-based coverage and $10.6 billion for coverage obtained outside the workplace. Individuals would also save another $12.4 billion in reduced out-of-pocket expenses. These savings to individuals would be partially offset by increased premium payments by nonworkers to cover their contribution to the cost of the minimum benefit package in the public program.

Costs to Government—State and local governments would save $7.4 billion under the Commission recommendations—the amount they currently spend on care for the uninsured over and above Medicaid spending. Limiting state contributions to the new federal program that replaces Medicaid would also relieve states of the growing burden for the medically indigent.

The federal government would pay an additional $24.0 billion (on the assumption of a 7 percent of payroll cap on employer contributions) (see Table 2-9). Of the total federal cost increase, payments for the public health insurance of nonworkers would be the largest item, costing $11.0 billion. Augmented Medicaid physician and hospital payments for people currently covered by Medicaid are estimated to cost $4.0 billion, due to the changeover to Medicare reimbursement rates. The cap on employer health expenditures (assumed to be set at 7 percent of payroll) would cost about $5.3 billion. Payment of premiums and cost sharing for workers with family incomes below 200 percent of poverty would cost $4.1 billion. Tax expenditures would grow by $5.6 billion as tax-favored health insurance expands. Partially offsetting these costs would be $6.0 billion saved as job-based coverage assumes costs now paid by Medicare, the federal share of Medicaid, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)—for military employees and their dependents.

Impact on the Private Insurance Market—The job-based private insurance market would expand under the Commission's recommendations. The scale of the expansion would depend heavily on the percentage of payroll cap set on the employer's contribution to the public plan. The lower the cap, the more numerous the firms that would choose coverage under the public plan and the fewer the firms that would seek private coverage for their workers. The Commission explored a range of options and, for estimating purposes only, used a 7 percent cap. At that level the numbers of workers brought into the public plan would be approximately equal to the number brought under job-based private insurance (24 million and 26 million, respectively) (see Figure 2-1).

Currently, 145 million Americans are covered by job-based private plans. Under a 7 percent of payroll cap, this number would rise to an estimated 171 million. If the cap were set lower, at 5.6 percent, for example, the number of private policyholders would still increase, but substantially less, to 151 million. If the cap were raised to 8 percent, 31 million additional individuals would be covered under private plans, raising the total of privately covered individuals to 176 million (see Table 2-10).

Table 2-8 Impact of Commission Plan on Individual Health Insurance Expenditures

(In Billions, 1990)

Employer plan premium payments	($5.7)
Nongroup plan premium payments	(10.6)
Premium payments for nonworkers	9.4
Household out-of-pocket	(12.4)
Total net change	($19.3)

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model.

Table 2-9 Impact of Commission Plan on Federal Expenditures

(In Billions, 1990)

Nonworkers covered under public plan	$11.0
Federal contribution to the public plan for workers (7.0% cap on employer costs)	5.3
Tax expenditure *	5.6
Payment of premiums and cost sharing for workers below 200% poverty	4.1
Augmented Medicaid physician and hospital payments	4.0
Savings to Medicare, CHAMPUS, Medicaid	(6.0)
Total	$24.0

* Tax expenditure=a loss of tax revenue.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model.

Impact on Service Use—Under current policy, total health care spending in the United States on people outside nursing homes is expected to reach just over $493 billion in 1990. Under the Commission's recommendations total health care spending would increase by an estimated $12 billion a year, as people's access to service improves. Of this overall increase, $5.3 billion would go toward inpatient hospital care and $3.5 billion would go toward physicians' services (see Table 2-11).

STRENGTHENING THE HEALTH CARE SYSTEM

The Commission recognizes that universal health care coverage can only be as sound as the health care system itself. Coverage that buys unnecessary or inappropriate care, that pays for poor quality, that fails to promote efficient delivery, or that shifts costs from some purchasers to others wastes private and public dollars that could be used elsewhere.

The Commission disagrees strongly with the view that the nation cannot extend coverage to the uninsured until we control health care costs and reform the health care system.

The Commission believes, on the contrary, that expanding access to quality care and containing costs through increased efficiency are equally urgent and fundamentally intertwined goals. Ultimate success in reaching either goal can only be achieved by an integrated strategy of system reform.

The Commission's blueprint for strengthening the health care system calls for development of a national system for quality assurance (to include measures to review the country's approach to medical malpractice), public and private initiatives to contain health care costs, specific interventions to ensure availability of care to underserved people and areas, and support for programs of health promotion and disease prevention.

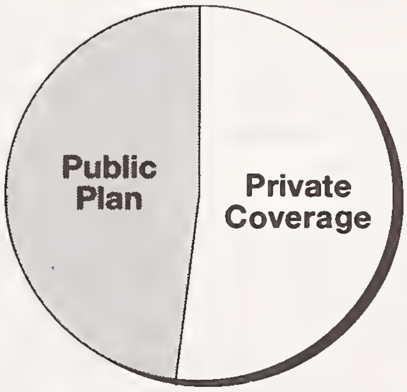
Quality Assurance and Malpractice Reform

The quality of the American health care system is uneven. Some Americans receive health care that is unrivaled in the world. For others, care is unnecessary at best and harmful at worst. Some Americans are completely unable to get the care they need.

The Commission believes it essential to ensure that all Americans receive appropriate care of high quality. The Commission recommends that the federal government develop and implement a comprehensive national system of quality assurance that includes five components.[19]

These components together represent a comprehensive national strategy to ensure a common scope and enforcement of requirements for quality assurance across all payers, public or private. The strategy would also facilitate examination of the content, medical necessity, appropriateness, and outcome of care,

Figure 2-1 Public-Private Split of New Worker Coverage Under Commission Plan



☐ 24 million workers and dependents
☐ 26 million workers and dependents

This figure illustrates how private and public insurance plans would divide some 50 million workers and dependents who would, on balance, be covered through their jobs due to Commission recommendations. It assumes a 7.0 percent payroll contribution rate for employers not choosing private insurance for their workers.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model.

Table 2-10 Coverage Under Public and Job-Based Private Health Insurance, Alternative Tax Rates *

Tax Rate	Persons in Public Coverage (In Millions)	Persons in Private Employment Coverage (In Millions)	New Government Costs (In Billions)
Alternative 1: 5.6% Payroll Contribution			
Current policy	22	145	—
Nonworker coverage under plan	13	—	$11.0
Change in worker coverage	43	6	7.8
Total Alternative 1	78	151	$18.8
Alternative 2: 7.0% Payroll Contribution			
Current policy	22	145	—
Nonworker coverage under plan	13	—	$11.0
Change in worker coverage	24	26	5.3
Total Alternative 2	59	171	$16.3
Alternative 3: 8.0% Payroll Contribution			
Current policy	22	145	—
Nonworker coverage under plan	13	—	$11.0
Change in worker coverage	19	31	4.2
Total Alternative 3	54	176	$15.2
Alternative 4: 6.0% Firms Under 25; 7.0% Firms 25-100; 8.0% All Other			
Current policy	22	145	—
Nonworker coverage under plan	13	—	$11.0
Change in worker coverage	25	25	4.8
Total Alternative 4	60	170	$15.8

* Newly covered persons include individuals who previously had coverage from outside the workplace, as well as the uninsured.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model.

regardless of when and where the care is provided or who pays for it. And it would respond to insurers, employers, consumers, and others in the health care system who are seeking ways to obtain information on quality of care.

1. *The Commission recommends development and implementation of national practice guidelines and standards of care, already begun by the newly created Agency for Health Care Policy and Research.* Physicians and physician organizations should be widely utilized in developing and reviewing the practice guidelines and parameters.

The Commission identifies as critical to a national system of quality the development of medical practice guidelines from research on necessity, appropriateness, and effectiveness in health care. The Commission does not intend these to be rigid instructions for a given condition. Rather, it envisions guidelines that outline the *range* of appropriate tests and procedures for a given clinical situation. Ideally, guidelines are developed by synthesizing a broad array of medical information, including scientific studies, available data, and expert opinion. The more uncertainty there is as to appropriate practice, the more room guidelines should leave for flexibility and variation. Under guidelines, physicians, of course, remain responsible for tailoring the treatment to what is most appropriate for the given patient. The goal is to prevent unnecessary or even harmful service use (observed in such areas as Caesarean deliveries or coronary bypass surgery) and to promote the use of necessary care.

The Commission recognizes that development and implementation of guidelines raise a number of issues.

First, development of guidelines would require additional information on medical care effectiveness and a process to translate that information into guidelines. To be effective, that process would set priorities, allow for review and testing, and provide for dissemination of results.

But simply developing the guidelines and making them public would not, by itself, ensure quality. Alternative strategies would also have to be explored for encouraging physicians to accept them and change practice patterns as needed. Finally, the guidelines and standards would have to be incorporated into effective programs for assessing and ensuring quality of care.

The Commission believes that the implementation of practice guidelines would reduce unnecessary, inappropriate, and ineffective care. Over time, it may also produce some savings to the system. Estimates

Table 2-11 Impact of Commission Plan on Health Care Expenditures by Type of Service for Noninstitutionalized People *

(In Billions, 1991)

Type of Service	Current Law Expenditures	Increased Utilization
Hospital inpatient	$181.4	$5.3
Hospital outpatient	38.7	1.4
Physicians	146.6	3.5
Dentists	49.7	0.3
Other professionals	17.9	0.3
Prescription drugs	33.2	0.9
Eyeglasses and appliances	12.4	0.0
Other health	13.4	0.3
Total	$493.3	$12.0

* Assumes Commission's plan is fully implemented in 1990.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model.

indicate that anywhere from $1.5 billion to $22 billion could be saved annually from changes in practice patterns.[20] The wide range of uncertainty is because the high estimates may fail to account for potential cost increases associated with practice guidelines. Such costs would come from alternative treatments that might be provided in place of procedures found to be inappropriate, or from increased use of services and procedures that are not now provided as often as they should be. Regardless of their impact on dollars spent, guidelines would enhance payers' confidence that they are purchasing necessary and valuable services.

2. *The Commission recommends development and implementation of a uniform data system that covers all health care encounters, regardless of payment source or setting.* These data would provide a common foundation for all payers' quality assessment activities and for examining the effectiveness of medical care, and identifying health policy and research concerns.

The Commission recognizes that better data collection is needed to support both the development of guidelines and the effective evaluation and oversight of health care across settings and providers. For example, evaluating the outcome of a surgical intervention requires knowing what happened to the patient after he or she left the hospital. An enhanced data base would also allow for the profiling of individual provider practice patterns based on care paid for by all purchasers rather than by a single purchaser. Currently, these types of analyses are often not possible.

3. *The Commission recommends development and testing of new, more effective methods of quality assurance and assessment.*

Enhancement of quality assurance mechanisms is another important component of a national quality assurance strategy. Quality assurance mechanisms are found throughout the health care system. Under the Medicare program, for example, the Health Care Financing Administration (HCFA) contracts with private organizations called Peer Review Organizations to review hospital and some outpatient services. PRO reviews are designed to ensure that Medicare pays for services that are medically necessary, provided in the appropriate setting, and of acceptable quality. Many states contract with the PROs to do quality assurance for their Medicaid programs. And private payers, such as large employers, are increasingly instituting utilization management and quality assurance programs to improve the value of services obtained for their investments.

These quality assurance programs generally emphasize utilization review. They seek to ensure that the care for which payment is made is medically necessary and reflects an appropriate claim. The review of quality tends to be limited to inspection and monitoring. Feedback to the provider is usually triggered by the finding of a problem; good quality is rarely recognized. The inspections are also generally done away from the actual site in which care was delivered. Rarely is there an attempt to track the entire episode of care, without which the reviewer cannot determine whether an identified quality problem stemmed from the most recent care episode or from care provided in a previous setting.

Existing quality assurance programs also lack adequate accountability. The current system involves "a mixture of public and private mechanisms that have developed along separate paths. The result is jurisdictional competition for turf, suspicion about motives, and questions about the sources and validity of criteria, standards, and data." [21] Physicians and other providers are uneasy about the reviewers. Reviewers, in turn, worry about their exposure to lawsuits by physicians and others who are adversely affected by the reviews.[22] Medicare PROs in some areas have been criticized by providers, for example, for ignoring the norms and standards of local practice. Conflicts like this tend to limit the effectiveness of PROs and other quality assurance programs in fulfilling their inspection and monitoring responsibilities.

Finally, there is little evidence to indicate that the existing quality assurance programs are in fact improving quality of care. The PRO program, for example, although its impact on quality has yet to be systematically evaluated, seems to have major weaknesses. According to a GAO study, the SuperPRO (a private organization that contracts with the Health Care Financing Administration) "regularly reviews a random sample of Medicare cases previously reviewed by PROs and typically questions the appropriateness of hospital admissions in almost six times as many cases as the PROs." [23] GAO studies of care provided by other government programs, such as military hospitals, reveal similar failings on the part of the quality assurance process to detect problems.[24] Less is known about quality assurance systems in the private sector.[25]

4. *The Commission recommends development and oversight of local review organizations that have skills in data integration and analysis, quality assessment, and quality assurance.*

The Commission's recommended improvements in review techniques are designed to enhance the performance of quality assurance programs while making their reviewers more accountable for their performance.[26] First, quality assurance activities need to be conducted by local review entities that are held accountable for identifying instances of poor quality and improving overall patterns of care within their geographical area. Such organizations should be close enough to the local community to enable their unique circumstances to be appropriately recognized. Physicians in rural communities, for example, should not be held to the same practice criteria as those providing care in urban, teaching hospitals. Yet rural and urban patients should be afforded care that is of the highest possible quality. Second, local review entities should have available a uniform set of methods for reviewing care (including practice guidelines and standards), developing and implementing interventions, and reporting information on the results of reviews and interventions.

Overall, the Commission views quality assurance as something more than quality assessment. Quality assurance requires identification and confirmation of problems in the quality of medical care. The process must also include intervention plans to lessen or eliminate the problems, track the effectiveness of the interventions, and institute additional changes and monitoring where warranted. To accomplish effective quality assurance requires the generation, compilation, and analysis of quality-related data, dissemination of those data back to providers and consumers, and accountability by those who do the monitoring.

5. *The Commission recommends that the Physician Payment Review Commission study and conduct demonstration projects related to medical malpractice reform in order to make recommendations to Congress on actions to be taken on the federal level. The appropriate committees of jurisdiction in Congress should also hold hearings on the malpractice issue, and the access legislation should incorporate professional liability reform.*

The Commission believes it essential to address the problems raised by malpractice and malpractice litigation. Despite growing concern, however, there is no consensus on how to resolve these problems.[27] Therefore, the Commission recommends neither the list of tort reforms that was put before it nor any other specific legislative actions.

To date, the major response to the malpractice situation has been actions by the states, both to modify the current tort system through reforms intended to reduce the amount both of litigation and of damages paid, and to provide for alternative dispute resolution (ADR) procedures. State action has included caps on damages for pain and suffering, periodic payments for damages, limits on lawyers' contingency fees, limiting joint and several liability, permitting or mandating the offset of collateral benefits (that is, benefits from another source), and shortening statutes of limitation.

Certain of the tort reforms—including caps on awards, mandating the offset of collateral benefits, and shortening the statutes of limitation—have reduced claims frequency or severity. However, limited information exists on the impact of such reforms on malpractice premiums.

State analysis and experimentation with alternatives to conventional tort reform have been undertaken with the policy aim of dealing not just with the concerns felt by doctors about the specter of high malpractice premiums or litigation, but also with the need of injured patients for accessible and adequate compensation for their losses, and of future patients for safer and higher quality medical care.

Several ADR mechanisms have been proposed or are being implemented. Arbitration is a process for resolving disputes outside the traditional judicial system. Statutes set forth procedures under which parties may agree to submit specific disputes for resolution by an impartial third party. Arbitration may be either voluntary or mandatory. Proponents of this approach suggest that it accelerates handling of claims and permits the use of decisionmakers who are experts in the field.

Pretrial screening panels are designed to screen out nonmeritorious claims prior to trial. The purpose is to discourage baseless claims and encourage settlement of claims.

No-fault compensation, which does not require proof of negligence, is designed to speed up the process leading to compensation. Both arbitration and pretrial screening panels operate within the fault system for determining liability for malpractice actions. Proponents of the no-fault alternative note that both the provider and patient are spared the anxiety of the fault determination or litigation process, and that prompt compensation may be made to a larger number of injured persons.

Replacing the existing judicial system with an alternative set of administrative procedures for handling malpractice claims is the final approach that has been suggested. Under this approach medical liability claims would be adjudicated by an administrative agency, with liability still established on the basis of fault. This plan would also expand the disciplinary process for physicians, strengthen physician credentialing, and mandate risk prevention programs and medical education. Proponents suggest that it should permit compensating more injured parties while at the same time eliminating windfall damage awards.

These ADR proposals offer the potential for improving the current malpractice situation. However, two concerns remain. The alternative approaches, while addressing some of the current concerns, may increase total compensation costs. Further, some have opposed eliminating the current fault-based system on the ground that this system may help deter medical negligence.

Given the general lack of success of conventional tort reform, and the fact that effects of these quite different methods of handling medical injuries, some of which may add costs to the system, are still being studied, it would be premature at this time to endorse specific legislative proposals. The malpractice problem has traditionally been under the jurisdiction of the states. However, concern about the connection between malpractice and rising costs, quality of care, and the well-being of patients is gaining attention at the federal level. What is needed now is careful analysis of the growing body of data and the design, implementation, and evaluation of demonstration projects involving one or more of these alternative ideas to design a national strategy for reform.

Cost Containment

Universal health care coverage can work effectively only if it buys high-quality services in an efficient and effective health care system. Because of the critical importance of linking increased health care access with improved service and financing efficiency, the Commission's recommendations have major cost containment implications. They would also reduce the current cost inequities among groups.

Controlling Costs—Health care cost containment alternatives have been researched and debated for at least two decades. Most proposals have relied on one of three basic approaches:

- Changing the behavior of consumers by holding them directly responsible for a larger portion of the costs of their own care,
- Changing the behavior of both providers and consumers by encouraging consumers to choose from among multiple health plans that compete on the basis of their ability to develop structured and efficient delivery systems,
- Changing provider behavior through reimbursement systems that provide incentives for greater efficiency.

The Commission believes that each of these three basic approaches has an important role to play in a comprehensive and multifaceted cost containment initiative. Policy discussion in this area often assumes that these approaches are mutually exclusive and that there is one best way of controlling costs. The Commission rejects this point of view. Use of all three approaches allows flexibility in pursuing the fundamental goal of modifying the incentives that govern decisions about the use of medical services.

1. Cost sharing in the Commission's recommended minimum benefit package would make consumers sensitive to price.

The Commission's recommendations would ensure that health insurance coverage is available for every American. While health insurance is an essential guarantor of access to care, there is also evidence that "first-dollar" coverage of medical costs leads to higher service use by freeing consumers of any need to consider the utility or price of the services they are consuming. Consumer demand is not the only factor propelling growth in health care costs. Still, there is widespread agreement that health insurance plans should include measures to encourage consumers to become more conscious of the price and utility of the medical services they use.

For this reason, the minimum benefit package recommended by the Commission includes cost sharing requirements. Deductibles are $250 for an individual and $500 for a family. Coinsurance is 20 percent for all services except prenatal care, well child care, and other preventive services, which are paid in full, and outpatient mental health care, for which 50 percent coinsurance applies.

Findings from a major health insurance experiment, however, raise a critical concern in the design of cost sharing requirements: their potential effect on the enrollees with the least income.[28]

Low-income enrollees in the cost sharing plans under the Health Insurance Experiment (HIE) responded to coinsurance requirements by delaying both necessary and unnecessary care. They had worse outcomes for a few specific conditions (such as hypertension) that can be improved by medical treatment. The Commission's plan exempts low-income enrollees from cost sharing requirements in order to ensure that the requirements would not deter necessary care. In addition, the plan waives cost sharing for preventive care, regardless of enrollee income, in order to avoid any disincentive for enrollees to obtain these potentially cost-effective services.

A second concern is that cost sharing without limits would create catastrophic burdens even for higher-income individuals, in the event of a high-cost illness. For this reason, the Commission's plan includes a $3,000 limit on out-of-pocket costs for individuals or families, in order to protect the most severely ill.

2. The Commission's recommended insurance reforms would lead insurers to compete around efficient service delivery, rather than for good risks.

The idea of reducing health care costs by promoting competition in the health care marketplace was first advanced in the 1970s. Proponents of competition contemplate a marketplace in which insurers develop structured delivery systems, with the highest profits going to those whose networks are most efficient.

The prototype for these new managed care systems is the health maintenance organization, a form of health insurer that accepts financial responsibility for a defined set of health care benefits in return for a fixed monthly per capita premium. Unlike other types of insurers, HMOs directly provide or arrange for health care services through affiliated physicians, hospitals, and other providers. They seek to reduce costs by managing the overall care of the patient. More recently, some insurers have been experimenting with hybrid programs, such as "point-of-service plans," which are less structured and provide somewhat greater flexibility for enrollees. These plans, too, aim to control overall service delivery to enrollees. As a result, HMOs and their competitors are often grouped under the single name of managed care.

While there is evidence that managed care can achieve real savings, the competitive strategy has been hampered by the tendency of the current insurance market to discourage competition on the basis of real efficiency.[29] Instead, competition often turns on such factors as the insurer's ability to screen out high-risk applicants or the consumer's inability to compare the values of different benefit packages.[30]

The Commission's insurance reform package seeks to lay the groundwork for real competition among insurers at the same time as it seeks to make insurance available to all. The requirements that insurers accept all group applicants and use comparable rating systems for all covered groups would ensure that the greatest rewards no longer go to the insurers who are most adept in attracting low-risk clients. The further requirement that insurers quote a premium rate for the standard minimum benefit package would establish a benchmark to be used by consumers in price comparisons. In addition, the collection and dissemination of data about quality would give consumers the knowledge needed to assess the price/quality trade-offs in competing insurance plans. The power of the market could then gradually induce all providers to make steady improvements in both quality and efficiency.

3. Extending managed care to small employers and including managed care as a means to provide the minimum benefit package in private insurance and the public plan would encourage efficient service delivery.

While the basic insurance reforms proposed by the Commission can help create the playing field on which real competition can occur, there is another barrier to be overcome before the benefits of market competition and managed care can reach all purchasers: the reluctance of insurers to make managed care plans available to small groups. Insurers who routinely include such managed care features as preadmission review and outpatient surgery programs in their large group contracts may not offer the same provisions to smaller firms. The effect is that small groups do not have access to the potential savings from these provisions. The smallest insured firms (one to nine employees) are only half as likely to have outpatient surgery or second surgical opinion programs as the largest firms (500 or more employees), and only one-eighth as likely to use preadmission review.[31]

Along with managed care options in job-based and public coverage, the Commission's recommendations include requirements that insurers who offer managed care provisions in large group contracts and who choose to enter the small group market offer the same provisions to smaller groups.

4. The Commission's recommended extension of Medicare payment rules to the public program would extend its increasingly effective payment controls and serve as a model for private insurance.

Traditional medical payment systems, under which providers receive their full costs or charges for whatever services they choose to furnish, may encourage inefficiency and the delivery of unnecessary care. In recent years, Medicare and some other third-party payers have moved to systems that give providers incentives to control both the volume of the services they furnish and the unit cost of those services.

Under Medicare's prospective payment system, a hospital receives a fixed predetermined payment for each case, with the amount of the payment varying by diagnosis and some other factors. If the hospital can furnish care for less than the payment amount, it may keep the difference; if it cannot, it may suffer a loss. The hospital is thus encouraged to provide care more efficiently.

Medicare's new payment system for physician services, which bases fees on the relative value of services rather than on physicians' historic charges, similarly aims to change the financial incentives that affect medical decision making. The old system paid more for surgery and other hands-on treatments than for such services as office consultations, thus encouraging physicians to adopt more aggressive treatments. The new system reverses these incentives and also provides, through "volume performance standards," for a general reassessment of payment rates if the volume of services provided grows too rapidly.

Medicare reforms are already serving as a model for the reimbursement systems of other payers. For example, many Blue Cross plans and state Medicaid programs have already adopted prospective hospital payment systems comparable to Medicare's. The Commission's plan would give a further impetus to this movement by requiring that the new public program that replaces and expands Medicaid would adopt Medicare payment methodologies, instead of the whole range of methods now used by the state Medicaid programs.

Adoption of the Medicare payment systems by the public program would have several potential effects on medical costs. First, by increasing the percentage of the total patient population covered under these systems, it would intensify the pressure on providers to respond with real increases in efficiency, rather than by cost shifting. Second, use of Medicare principles by a program serving a younger population might encourage use of similar methodologies by insurers who had previously rejected them as applicable only to seniors. Finally, replacement of the current state Medicaid payment systems would reduce the cost shifting that may now be occurring in states whose Medicaid reimbursement levels are below providers' actual costs.

5. Adoption of a comprehensive quality assurance strategy, ultimately including reform of the medical malpractice system, would ensure greater value for the dollar in the delivery of health care services.

The United States spends proportionately more on health care than any other country, yet does worse than many countries on standard health status measures such as infant mortality and life expectancy. The Commission believes that costs cannot be contained without far greater knowledge about the value of the health care services our expenditures buy.

The Commission believes that its recommendations for quality assurance will provide that knowledge and put it to use—fundamentally reforming the nation's health care system.

The Commission's recommendation that uniform data be collected on the services rendered by all health care providers and that research be conducted on the outcomes of those services will permit comparative evaluations to be made of the efficacy of different medical practices and the performance of different providers. These comparative evaluations—in conjunction with payment incentives just described—would allow providers to control costs by choosing the most cost-effective treatment mode. And they would further promote cost control by enabling payers and consumers to make rational purchasing decisions in the health care market—essential for the efficient operation of private and public insurance.

Reducing Cost Inequities Among Groups—At least part of the concern about health care costs stems from unequal cost burdens among different groups in society. Three aspects of the Commission's recommendations would reduce the health care costs of groups that now bear a disproportionate share of the health care financing burden:

1. Reducing the cost shift that now occurs from the uninsured to the insured population would reduce costs for the employers and insurers currently paying indirectly for uncompensated care.

Much of the cost of bad debt and charity care that is not offset by government subsidies is passed on to insurers and employers in the form of higher charges. By ensuring coverage for every American, the Commission's plan, would virtually eliminate uncompensated care.

2. Reducing the cost shift that now occurs from employers who do not provide insurance to employers who cover their workers and dependents would reduce the per worker cost of health benefits for employers already offering coverage.

Under the current system, employers who provide health benefits are covering an average of one worker employed at another firm for every four of their own workers.[32] To a considerable extent, the burden is shifted from small to large firms because the latter are more likely to provide coverage. Under the Commission's plan, each worker would obtain coverage from his or her own employer, and the dependent children would be more equitably divided among employers.

3. Ensuring small business access to a minimum benefit package at a predictable rate, regardless of employees' health status, would provide affordable insurance coverage for all.

Some practices in the current insurance market make employee coverage unaffordable for many small businesses. A firm may pay higher rates at the outset, or face large increases when it tries to renew coverage, if it has a single potentially costly employee. In addition, administrative costs are higher for small groups than for large ones—in part because the screening out of poor risks in itself entails costs.[33] The Commission's insurance reform recommendations would provide equitable rates for all purchasers and would reduce the costs of screening individuals.

Besides the cost control implications of the recommendations the Commission has made so far, the Commission believes that a mechanism is essential to assess, on a continuing basis, the trends in health care costs and the record of efforts to control those costs.

Full implementation of the Commission's recommendations would have dramatic impacts on consumers, providers, and insurers—changing their behavior in ways that may not be entirely predictable before the new systems take effect. At the same time, there would be continuing advances both in medical technology and in our understanding of how to make the best use of that technology.

The impacts of both implementation of the Commission's proposals and of new medical technologies must be continuously monitored and assessed by the policy process. *The Commission recommends that the Prospective Payment Assessment Commission and the Physician Payment Review Commission assess cost experience and initiatives to contain costs in the public and private sectors and make periodic recommendations to Congress on federal initiatives.* This expansion of the current charge of these advisory bodies, which now focus mainly on Medicare, is appropriate in light of the expansion of the federal role in the health system contemplated by the Commission—including both the expanded and federalized public plan and the new federal role in ensuring minimum standards in the private health insurance sector.

Access for the Underserved

The Commission recognizes that ensuring universal health care coverage is necessary but not sufficient to guarantee all Americans access to the care they need. Residents of isolated rural areas or inner cities, the poor, minority groups, high-risk pregnant women and their infants, the homeless, the elderly, the mentally ill, the mentally handicapped, individuals with HIV infections, and substance abusers are among the groups for whom a commitment to pay the bills may not be enough to guarantee appropriate care. Many persons fall into more than one of these groups.

EARL DOTTER

High-risk pregnant women and their infants are among the underserved groups targeted to receive special assistance.

Some areas suffer from a dearth of health care facilities, personnel, and other resources needed for the routine provision of services at the local level. Even if facilities and services are available, fragmentation (that is, services offered through multiple organizations in various locations) and poor coordination prevent effective delivery in some areas. Finally, language, racial, educational, cultural, and attitudinal differences impose special barriers to effective delivery of health and social services to certain groups.

To address these special needs, the Commission endorses actions to promote primary care delivery systems for underserved population groups and adequacy of personnel and facilities in underserved areas.[34]

Primary Care Delivery Systems—The Commission believes that expanding health care insurance coverage should reinforce—not replace—support for primary care delivery systems targeted at the poor and underserved. *The Commission recommends that organized primary care providers (local health departments and community health centers, for example) should be recognized and reimbursed by private and public payers on the same basis as all other providers.*

Depending on their design, financing reforms can increase the capacity of direct delivery providers. Currently, some organized programs receive less payment from insurers than do other providers offering the same service or are not recognized as providers at all. Eliminating this discrimination and covering patients previously uninsured or underinsured would enable delivery systems to use their state, federal, or private funds to develop additional facilities, to expand types of services and the number of patients served at existing facilities, and to provide additional outreach and case management services. Thus, insurance and service delivery approaches to ensuring access to care can be synergistic.

Several types of subsidized service delivery programs serve those individuals who lack a regular private sector primary care physician. At the federal level, the Bureau of Health Care Delivery and Assistance of the Department of Health and Human Services (HHS) is responsible for programs that bring community-based primary health care to approximately 6 million poor and underserved persons through grants and manpower recruitment. The Indian Health Service (IHS) provides primary care services through a variety of urban and rural programs to more than 1 million persons per year; however, only 1 percent of IHS money pays for care of urban Indians.[35] Two federal grant programs (the Maternal and Child Health Services block grant, and the Preventive Health and Health Services block grant) help support primary care services to underserved populations, usually provided through state and local health departments.

Approximately 25 percent of local health departments have gone beyond offering discrete single health services, and now provide primary care. Hospitals are the only family doctor in many areas, in that underserved persons often rely on hospital emergency rooms or organized outpatient departments as their principal source of primary care. School-based health centers offer primary health care through 150 health centers operating in junior and senior high schools in both urban and rural areas. Finally, the private sector operates nonpublicly funded health centers throughout the country.

A number of studies have shown that existing primary care programs have made significant inroads in reducing barriers to the receipt of appropriate health care, and improving health status and outcomes. For example, the effectiveness of community-based health centers is evidenced by the fact that Medicaid patients who use these centers have lower hospital admission rates, shorter lengths of stay, and make less inappropriate use of emergency rooms than comparable patients who have Medicaid coverage but do not use a community health center. Similarly, health centers have had a beneficial effect on both white and black infant mortality rates, have reduced rheumatic fever and untreated middle ear infections, and have brought about an increase in the number of immunized children. Unfortunately, most of the research in this area was conducted in the 1970s and early 1980s.

The Commission believes that further progress in reaching underserved, vulnerable populations requires availability of a coordinated broad continuum of services. Innovative organized primary care delivery sites now exist that have succeeded in building the needed range of services. The challenge is to facilitate the extension of these successful program models to the other areas in need.

Experience indicates that to be effective, programs targeted at hard-to-serve populations must include several elements.

First, they must make services physically accessible to the population they intend to serve and provide a sufficient number of appropriately trained professionals who are sensitive to cultural, ethnic, and language differences.

Second, they must provide case management, and where possible, colocation of a broad range of health, welfare, and other support services, including such services as medical referrals, nutrition counseling, income support, food programs, and housing assistance. *The Commission recommends that coordination be encouraged by providing federal support for establishing "one-stop shopping programs," and technical assistance to simplify and standardize eligibility requirements and procedures for a multitude of federal and state programs.*

Third, effective primary care systems must include outreach and other social services which encourage early entry into the health and social service system and encourage at-risk populations to maintain participation in care. *The Commission recommends that federal support be provided to local outreach and facilitating services—preferably linked to health care delivery programs—to encourage patients to seek and continue to participate in health care.*

Examples of such services include health education programs, transportation and home visiting, on-site day care, and bilingual services. Strategies to support outreach and other services might include, but are not limited to: (a) providing demonstration grants to enlist volunteers from the community, along with the training and management necessary to ensure appropriate use and retention of volunteers; (b) encouraging communities to provide free or reduced-cost transportation for pregnant women and other high risk, underserved groups; and (c) working with states and localities to promote availability of home visits by public health nurses in underserved areas.

Fourth, although much has recently been learned about what programs are effective in reaching the underserved, more knowledge is urgently needed. *The Commission recommends that the federal government support research and evaluation efforts that focus on determining the effectiveness of different primary care models and services aimed at addressing the needs of underserved communities.* A crucial part of this effort must be to help local programs set up systems to collect program and monitoring data that allow long-term evaluation as well as short-term feedback.

The Commission believes that efforts to ensure adequate availability of all services require special attention to treatment for problems of alcoholism and drug abuse. Consequently *the Commission recommends federal support for a continuum of care—through organized delivery systems and other means—that includes short-term hospital-based or longer-term community-based alcoholism and other drug treatment services.*

Adequate Personnel and Services—Alongside support for primary care delivery systems, *the Commission recommends that the federal government should promote an adequate supply and appropriate mix of personnel and facilities for underserved areas and populations, through provider payment methods in public programs that promote availability of primary care practitioners and facilities and ensure access to other needed services, and through special initiatives to attract a range of providers to underserved areas.*

The Commission's recommendation that the new public coverage program follow the Medicare program's provider payment methods will significantly improve availability of primary care providers for all segments of the population, especially the currently underserved.

Medicare is in the process of implementing a new method of physician payment—the resource-based relative value scale—that pays national rates (adjusted to reflect differences in local overhead costs) for physician services according to the resources involved in providing those services. The RBRVS fee schedule is designed to correct current financial incentives favoring expensive technology over cognitive physician services. In addition, the national fee schedule should correct current financial disincentives that discourage doctors from practicing in underreimbursed locations. This reform will substantially improve payment for services for primary care (by an estimated 30 percent, on average) and for physicians' practices in rural areas (by an estimated 13 percent, on average).[36] A program of bonus payments to physicians in urban and rural health manpower shortage areas further reinforces these reform objectives.

The Commission regards Medicare's new payment method as critical to ensuring the availability of appropriate care, both in general and in areas now underserved. In extending this payment method for physicians to the recommended federal public coverage program, the Commission intends to promote availability of services under that program and, by providing a model payment mechanism for private payers, for other groups as well.

The Commission also recognizes ongoing refinements in Medicare's prospective payment system for rural hospitals to ensure adequate support for these hospitals and other services in rural areas. Rural hospitals have received larger annual rate increases than urban hospitals over the past three years. Sole community hospital designation has been expanded, along with eligibility for disproportionate share adjustments to hospitals serving high proportions of low-income patients.[37]

Other measures have also been taken to further secure services in rural areas. In the Omnibus Budget

Reconciliation Act of 1987, a rural health transition grant program was included that provides federal funding for small, rural hospitals to diversify health services, recruit health care professionals, and improve hospital management in order to improve access to health services for Medicare beneficiaries.[38] Montana is currently undertaking a pilot project establishing Medical Assistance Facilities (MAFs). MAFs are short-stay, low-intensity facilities that provide emergency and inpatient care. MAFs are staffed by a wide range of health care practitioners, such as physician assistants and nurse practitioners.[39]

More recently, a new Essential Access Community Hospital (EACH) program was approved by Congress. Under this demonstration grant program, seven states are eligible for federal funding to develop rural health care networks to promote the regionalization of rural health services, improve access, and enhance rural emergency and transportation services.[40] It is the Commission's intent that its recommended new public program would incorporate measures developed through these demonstration projects, along with special payment adjustments, to support adequate rural services.

The Commission recognizes that even payment methods designed to pay adequately in underserved areas may be insufficient to attract adequate numbers of providers. Consequently, *the Commission recommends further efforts to attract and retain health professionals.* Promising strategies include: (a) increased support for programs like the National Health Service Corps and other financial incentive programs; (b) promotion of the appropriate use of mid-level health professionals through development of model state practice acts; (c) further study of problems regarding professional liability; and (d) development of professional support networks, such as telecommunications networks with other providers to offer adequate backup and support services.

Preventing Illness and Promoting Health

The Commission's commitment to universal coverage in an efficient and effective health care system goes beyond ensuring access to treatment. Preventing the *need* for treatment safeguards secure, productive lives for all Americans and uses the nation's resources most efficiently.

The Commission recognizes that a higher proportion of low-birthweight babies, higher infant mortality rates, and lower life expectancies than other nations may reflect more than the inability of many Americans to receive needed health care. It may also indicate a relative lack of emphasis on early detection and screening for particular conditions, promotion of healthier lifestyles, and more and better education on health-related topics.

The Commission therefore recommends federal support for programs of health promotion, disease prevention, risk reduction, and health education toward the reduction of excess morbidity and mortality and toward the increase of healthy lifestyles. Federal support for such programs should eventually total at least $1.0 billion annually beyond current federal efforts.

IMPROVING PROTECTION FOR PEOPLE 65 AND OVER

The above recommendations apply primarily to Americans under age 65. Nearly all elderly Americans receive their basic health insurance protection from Medicare.[41] But gaps in Medicare protection expose the elderly to considerable financial risk.[42]

To address these gaps in health care coverage for the elderly population, the Commission recommends modifications in coverage in the following three areas:

- Protection for the low-income elderly population comparable to protection the Commission recommends for the low-income population under age 65;
- Changes in Medicare benefits for all elderly and disabled beneficiaries, to include preventive services comparable to those the Commission recommends for people under age 65;
- Reforms in the private insurance market that supplements Medicare coverage to ensure adequate protection for the nonpoor elderly that are complementary to the other reforms in private insurance the Commission recommends.

These recommendations would, in combination, benefit 30 million Americans over age 65 at a total new federal cost of $2.8 billion.

Assisting the Low-Income Elderly

For the nonelderly low-income population, the Commission's recommendations call for the newly established federal public plan to subsidize fully all premiums, deductibles, and coinsurance for individuals or families with incomes up to the federal poverty level and provide partial subsidies at least to those with incomes between 100 percent and 200 percent of pov-

JENNIFER DUNCAN/PROVIDENCE HOSPITAL

Commission recommendations fill gaps in Medicare, improving protection for 30 million elderly Americans.

erty. Comparable protection is not currently provided to the low-income elderly population.

Today, there are 3.5 million poor elderly people with incomes below 100 percent of the federal poverty line, roughly $6,000 per year. An additional 8.2 million elderly people are near-poor, with incomes between 100 percent and 200 percent of poverty (see Figure 2–2). Low-income elderly people are more likely to be in poor health and suffer from chronic conditions than higher-income elderly people. In addition, low-income elderly people are less likely than others to have coverage to supplement Medicare. One-third have neither Medicaid nor private insurance and rely solely on Medicare coverage.

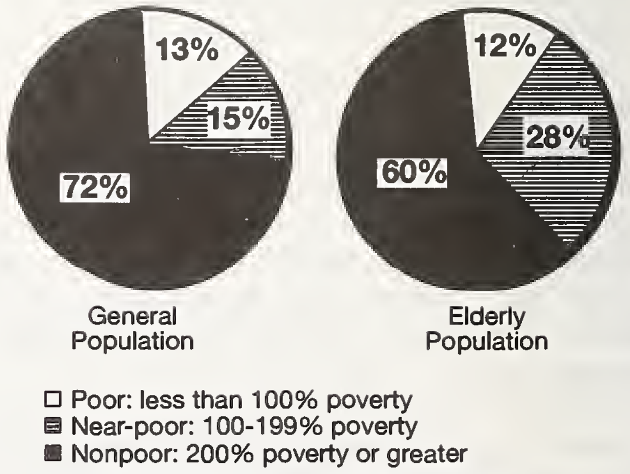
Gaps in coverage under Medicare can result in catastrophic out-of-pocket payments for low-income elderly people.

- On average, they spend 14 percent of per capita income on out-of-pocket costs in contrast to 7 percent of income for higher-income people.
- The out-of-pocket costs associated with Medicare premium payments ($343 a year in 1990) and routine cost sharing requirements can impose a heavy financial burden on these low-income elderly people.
- At a cost of $500 a year for Medigap policies, protecting against Medicare cost sharing also means severe out of pocket burdens for low-income people.
- Medicaid buy-in assistance helps by paying the Medicare premium and cost sharing for certain low-income people. But the near-poor will not be helped by the buy-in provisions in current law. Without strong outreach efforts some of the poor will also be left out.

The Commission recommends that Medicare, or the public plan that replaces Medicaid at the federal level, provide assistance with the Medicare premium, deductibles, and cost sharing to all elderly people with incomes below 200 percent of poverty and undertake strong outreach efforts to ensure participation.

- The 3.5 million elderly people with incomes below the poverty level (the poor) would be eligible and encouraged to receive full assistance with Medicare premiums, deductibles, and coinsurance from Medicare or the public plan.[43]
- The 8.2 million elderly people with incomes between 100 percent and 200 percent of poverty (the near-poor) would be assisted with payment of premiums, deductibles, and coinsurance on an income-based sliding scale by Medicare or the public plan.

Figure 2-2 Distribution of the General Population and the Elderly Population, by Income Relative to Poverty Level, 1988



SOURCE: For the elderly, Congressional Budget Office estimates based on the Current Population Survey, March 1989.
For the general population, the Current Population Survey, March 1989.

The cost of offering premium and cost sharing protection to the low-income elderly population is estimated to be $2.6 billion in additional federal resources in 1990 (see Table 2–12). This cost includes $0.39 billion for fully subsidizing all the poor and $2.21 billion for partially subsidizing the near-poor. New federal costs for the poor reflect the assumption that more people would participate in benefits offered by Medicare or the new federal program than were expected to participate under Medicaid. (Cost estimates assume 100 percent participation for the poor—in contrast to the 65 percent that the Congressional Budget Office (CBO) assumed in estimating the costs under current law.) Costs for the near-poor include federal absorption of amounts states are now spending on this population ($0.26 billion).

States would be expected to continue their responsibility for sharing the costs of coverage for people with incomes below poverty, as specified under current law. If participation under the new federal program were to reach 100 percent, rather than the 65 percent CBO assumed, this responsibility would result in new state costs of $0.32 billion.

Improving Medicare Benefits

The Commission has recommended that health insurance benefits for people under 65 include preventive care.[44] Among the services to be covered are mammography, pap smears, colorectal and prostate screening procedures, and other preventive measures that are effective relative to cost. Consistent with the benefits for the under-65 population, *the Commission recommends that Medicare be expanded to provide selected preventive services. Preventive services to be added include mammography, and colorectal and prostate screening services.*

Pap smears were added to Medicare by OBRA 1989. Although periodic screening for breast, colorectal, and prostate cancer are not currently covered, such procedures would facilitate early detection

Table 2–12 Impact of Proposal to Expand Protection for the Low-Income Elderly Population, 1990

	Total Covered Population (In Millions)	Cost (In Billions)			
		Current Law			New Costs to Federal Government Under Proposed Public Plan
		Total	Federal	State	
Poor elderly people: less than 100% poverty					
Current Medicaid beneficiaries	1.0	0.99	0.54	0.45	—
Current Medicaid eligibles [a]	1.6	1.27	0.70	0.57	—
New eligibles [b]	0.9	—	—	—	0.39
Total poor elderly people	3.5	$2.26	$1.24	$1.02	$0.39
Near-poor elderly people:					
100–150% poverty					
Current Medicaid beneficiaries	0.6	0.47	0.26	0.21	0.21 [c]
New eligibles	3.9	—	—	—	1.27 [d]
150–200% poverty					
Current Medicaid beneficiaries	0.2	0.12	0.07	0.05	0.05 [c]
New eligibles	3.5	—	—	—	*0.68 [d]
Total near-poor elderly people	8.2	$0.59	$0.33	$0.26	$2.21
Total low-income elderly population	11.7	$2.85	$1.57	$1.28	$2.60

a Eligible under current law, which will expand eligibility for buy-in assistance to 100 percent of poverty in 1992. Costs based on CBO expected participation rate of 65 percent.

b Assumes 100 percent participation of people below poverty, as federal public program replaces Medicaid. Full participation would entail state costs of $0.32 billion above CBO's previous projections.

c A cost that states are expected to bear under current law which will be absorbed by the federal government.

d Assumes 50 percent participation rate.

SOURCE: D. Rowland, 1990, based on CBO estimates of elderly Medicare enrollees' cost sharing liabilities for calendar year 1990 prepared by Sandra Christensen. Estimates assume cost sharing based on Medicare payment rates.

and treatment of these potentially devastating diseases. As was recommended for the under-65 group, other preventive services should be added when they are established as effective relative to costs.

If adopted, these provisions would increase federal Medicare spending by about $0.2 billion in 1990.[45]

Reforming the Medigap Market

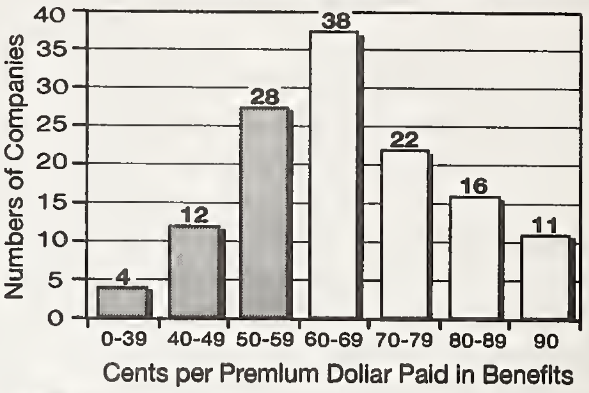
Private insurance (usually termed Medigap) supplements Medicare for four out of five nonpoor elderly people.[46] However, continued congressional oversight has documented that the Medigap market has historically been subject to considerable abuse by companies and salespersons whose products do not live up to their claims.

The problems with Medigap can be roughly divided into issues related to the quality of the information on plans and the way plans are marketed, whether policies offer reasonable value, underwriting practices, and affordability. To some extent these issues are intertwined, but it is useful to discuss each individually.

Choosing appropriate Medigap plans remains a difficult task for many elderly persons because of the complexity of the choices and problems with unscrupulous salespersons.[47] Plans offer many different options, making comparisons among them difficult. Terminology may vary even when the coverage is exactly the same, creating further obstacles for consumers. There is some evidence that the structure of agent sales commissions provides a powerful incentive to replace or duplicate existing policies.[48] Commissions on the sale of initial policies are often several multiples of the renewal commission. These practices aggravate the fears of older persons and play on their desire to protect themselves. At least 12 states now have programs to help the elderly make choices.[49] They may offer counseling for direct information on specific decisions, or require that insurers in the state provide information in a form that can be easily compared and understood. In some cases states even specify what services must be covered.[50]

GAO findings indicate that loss ratios for policies offered by some commercial insurance companies are well below the federal standard of 60 percent for individual policies (see Figure 2-3).[51] (The loss ratio indicates the amount of benefits paid per dollar of premium received.) In these cases individuals are not getting their money's worth from their policies. Loss ratios for Blue Cross/Blue Shield and some of the larger private insurers (especially under group policies) often exceed 80 percent.[52] With federal standards as a minimum, states determine whether Medigap policies have acceptable loss ratios. But until recently they did not have data from insurers on actual experience to enforce loss ratio rules. State enforcement efforts are critical to ensuring the elderly adequate protection.

Figure 2-3 Medigap Loss Ratios for Individual Policies Offered by Selected Commercial Insurers, 1988



▨ Fails to meet federal standard of 60 cents per premium dollar paid in benefits

☐ Meets or exceeds federal standard of 60 cents per premium dollar

SOURCE: General Accounting Office, Medigap Insurance Testimony, T-HRD-90-16, March 13, 1990, Appendix III.

The underwriting practices of insurance companies influence the fairness of the treatment of policyholders and their access to policies. Medical underwriting is becoming more common. Insurers who were once willing to take all applicants now may screen out the bad risks, holding down their own premiums but forcing those with health problems to go without supplemental insurance or to cluster in plans such as Blue Cross/Blue Shield that have open enrollment. Over time, the plans that take all comers may become inordinately expensive.

The rapidly rising costs of Medigap premiums represent the most visible problem facing elderly consumers. They may drive some of the near-poor out of the Medigap market and leave them vulnerable to large out-of-pocket expenses. For those policies that do offer good value for their costs, higher premiums reflect the general problem of health care price inflation. Solutions to increases from these sources will likely only come as part of a more general solution to overall health care prices.

The Commission recommends federal action to ensure the nonpoor elderly access to adequate coverage through insurance reforms that are generally consistent with re-

forms the Commission recommends for other health insurance plans.

Specifically, legislation should be enacted to fund state or local programs that would advise Medigap purchasers on the quality, price, and benefits of Medigap policies. This would enable the elderly to compare policies making certain they suit an individual's needs.

Legislation is also recommended to establish additional federal Medigap standards within the existing enforcement framework. The standards would:

- Require insurers to maintain loss ratios of 70 percent or higher for individual policies (up from the current requirement of 60 percent) and 80 percent or higher for group policies (up from the current 75 percent);
- Require specific financial or other penalties for insurers who fail to comply with minimum loss ratio and other requirements;
- Require development of model Medigap policies that simplify and make uniform the language and format of policies to ensure comparability. Several standard policies or components of policies should be developed that insurers must offer in addition to any they wish to offer;
- Require insurers to offer an open enrollment period, with no preexisting condition exclusions and guaranteed renewability of policies;[53]
- Specify measures (such as federal or state registries) to prevent duplicate coverage, including the sale of any Medigap policies to beneficiaries of public subsidies to fill Medicare's gaps;
- Require limiting the commission on initial policies to no more than 200 percent of the renewal commission, and that commissions on replacement policies be no more than the amounts for renewals;
- Require the Secretary of HHS, within two years of enactment of these provisions, to assess the adequacy of Medigap regulation by the states and report to Congress on further needed initiatives, including greater federal involvement in the regulatory process.

The costs of these changes would stem from supporting states' counseling efforts and would be $25 million in 1990.

Notes to Chapter 2

1. The recommendations assume that an approach would be devised to assign children in two-worker families to one or the other of the parent's plan in an equitable manner. Some insurers now coordinate benefits by covering the children under the plan of the parent whose birthday comes earlier in the year.

2. Consistent with the principle of shared employer-employee responsibility, the minimum employer contribution would represent 80 percent of the total contribution. An additional 20 percent could come from the employee, paid as a share of wages.

3. To minimize insurers' concerns about adverse selection as coverage expands, it may be appropriate to allow a limited waiting period for coverage of pre-existing conditions—for people who in the previous period (prior to the implementation of these recommendations) did not have health insurance. That is, for those with health insurance who change employers or for employers that change health insurance plans, preexisting condition limitations would not be allowed. But for those entering the work force in the future or for those whose employer did not provide health insurance, a one-time waiting period for coverage for the preexisting condition may be warranted.

4. Provisions (a) and (b) would also apply to all employer-provided insurance, in large as well as small firms.

5. The Commission recognizes the need to adjust the rate by both the family size and by the health care costs of the area. Differences in health care costs would be captured by virtue of insurer freedom to set rates in each area of the country. Discussion of the single rate is not meant to preclude having both a single individual rate and a single family rate.

6. Payment rates set by these methods are based on Medicare experience. Adjustments might be needed to set rates for a nonelderly population.

7. The benefit plan for the public program also covers current Medicaid mandatory services including Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) services, as discussed below, home health services, Skilled Nursing Facility (SNF) services, and family planning services (as preventive services). These services are included in order not to make low income persons worse off than they are now.

8. All services must be available to all members of the family including newly born children from the moment of birth.

9. The term "physician office visits" assumes that, as under Medicare and Medicaid, health care providers other than physicians would be reimbursed for this service.

10. Hospital, surgical and physician services covered in the plan include medically necessary prenatal, delivery and postpartum care, including services for complications of pregnancy, labor and delivery and postpartum recovery care.

11. In addition to well child care, the benefit package for children who participate in the public plan includes Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) services which is now a mandatory service for all Medicaid beneficiaries. The services in EPSDT which are beyond the well child care include screening, diagnosis, and treatment for dental, hearing, vision, chronic mental health problems and developmental delays, and any other problems uncovered in screening. The plan allows families with private insurance to buy this "wraparound" coverage from the public plan for their children at cost (or at a subsidized cost if their income is less than at least 200% of poverty).

12. John Sheils, unpublished analysis of Lewin/ICF *Employer Health Plan Survey,* for the Pepper Commission, 1990.

13. Cathy Hurwit, "Discretionary Income Compared to Poverty Level and Family Size," National Health Care Campaign (1990); Sue Goldberger, "The Development of an Affordable Sliding Fee Scale," a study prepared for the Study Commission on Health Care Financing and Delivery Reform (January 1989); Jane Kolodinsky and Thomas Arnold, "Developing a Sliding Fee Scale for Health Care Insurance in Vermont—The Calculation of Disposable Income," prepared for Vermont Health Insurance Plan (June 1989).

14. U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1986* (Washington, D.C., June 1987) and A. Foster Higgins & Co., *Foster Higgins Health Care Benefits Survey, 1987* (1987).

15. Health Care Financing Administration, *Medicaid Services State by State* (Washington, D.C.: Government Printing Office, 1990) [HCFA Pub. No. 02155-90]

16. John Sheils, unpublished analysis of March, 1988 Current Population Survey Data for the Pepper Commission, 1990.

17. For methodology used in determining these estimates, see Appendix D, "Assumptions Used to Estimate Costs for Health Care Recommendations."

18. Charles Brown, "Minimum Wage Laws: Are They Overrated?" *Journal of Economic Perspectives* 2 (3) (1988): 133–146.

19. The following discussion is drawn from: General Accounting Office, *Quality Assurance, A Comprehensive National Strategy for Health Care is Needed* (Washington, D.C.: GAO/PEMD-90-14BR, February 1990). This report was prepared for the Commission and is included in Pepper Commission, *A Call for Action,* Supplement to the Final Report (Washington, D.C.: Government Printing Office, 1990).

20. National Leadership Commission on Health Care, *For the Health of a Nation: A Shared Responsibility* (Ann Arbor: Health Administration Press, 1989).

21. Kathleen N. Lohr, Karl D. Yordy, and Samuel O. Thier, "Current Issues in Quality of Care," *Health Affairs,* 8 (1) (Spring 1988): 13–14.

22. U.S. Congress, House Committee on Ways and Means, *Medical Malpractice,* prepared by the Congressional Research Service, 101st Cong., 2d Sess., 1990, WMCP 101-26. [Hereinafter cited as Ways and Means, *Medical Malpractice.*]

23. General Accounting Office, *Quality Assurance,* 19.

24. Ibid.

25. A recent review by the Institute of Medicine of private sector utilization management programs concluded that systematic evidence about their effects on quality of care is nonexistent. See Institute of Medicine, *Controlling Costs and Changing Patient Care? The Role of Utilization Management* (Washington, D.C.: National Academy Press, 1989), 4.

26. These steps to improving quality assurance are based on suggestions made to the commission by the General Accounting Office, *Quality Assurance,* 18–22.

27. This section relies on Paul Weiler and Troyen A. Brennen, "Medical Malpractice" in Pepper Commission, *A Call for Action,* Supplement to the Final Report (Washington, D.C.: Government Printing Office, 1990).

28. This summary is drawn from Kathleen Lohr et al., "Use of Medical Care in the RAND Health Insurance Experiment: Diagnosis and Service-Specific Analyses in a Randomized Controlled Trial," *Medical Care* 24 (9) (Supplement) (September 1986): S74–S77; and Robert H. Brook et al., "Does Free Care Improve Adults' Health?: Results From a Randomized Controlled Trial," *New England Journal of Medicine* 309 (23) (December 8, 1983): 1426–34.

29. For a review of this evidence see Mark Merlis, "Controlling Health Care Costs," (Washington, D.C.: Congressional Research Service Report No. 90-64 EPW, January 1990).

30. Alain Enthoven has summarized the alternatives to price competition: "[S]election of preferred risks, market segmentation, product differentiation that raises the costs of comparing products, discontinuity in coverage, refusal to insure certain individuals of exclusion of coverage for treatment of preexisting medical conditions, biased information regarding coverage and quality, and erection of entry barriers [that is, to new competitors]." Alain C. Enthoven, "Managed Competition of Alternative Delivery Systems," *Journal of Health Politics, Policy and Law* 13 (2): 305-321.

31. ICF, Inc., *Health Care Coverage and Costs in Small and Large Businesses,* Final Report, prepared for Office of Advocacy, Small Business Administration (Washington, D.C., April 15, 1987) V-3.

32. John Sheils, analysis of the Current Population Survey, March 1988, prepared for the Pepper Commission.

33. U.S. Congress, House Committee on Education and Labor and Energy and Commerce and Senate Special Committee on Aging, *Insuring the Uninsured: Options and Analysis,* report prepared by Congressional Research Service, 100th Cong., 2d Sess., 1988, Education and Labor Committee Print 100-DD, L4.

34. The following discussion draws from Bonnie Lefkowitz and Judy Rodgers, "Primary Care Service Delivery Programs—A Critical Element to Ensuring Access to Care," in Pepper Commission, *A Call for Action,* Supplement to the Final Report (Washington, D.C.: Government Printing Office, 1990).

35. Office of Management and Budget, *Budget of the United States Government: Fiscal Year 1991* (Washington, D.C.).

36. Physician Payment Review Commission, *Annual Report to Congress* (Washington, D.C., 1990)

37. Prospective Payment Assessment Commission, *Medicare Prospective Payment and the American Health Care System: Report to the Congress* (Washington, D.C.: June 1990), 22–28.

38. Omnibus Budget Reconciliation Act of 1987. P.L. 100–203, Sec. 4005(e).

39. Pepper Commission, *Rural Health Care: The Frontier Perspective,* Hearing, 101st Cong. 1st Sess. (Missoula, Mont., June 28, 1989).

40. Omnibus Budget Reconciliation Act of 1989, P.L. 101–239, Sec. 6003(g).

41. In addition to calling for recommendations on health care for all Americans and on long-term care for the elderly and disabled, the statute establishing the Commission calls for recommendations on health care for the elderly and disabled. The following recommendations focus on the elderly because the disabled population is part of the general population under age 65 and is included in the health care recommendations already presented. Disabled Medicare beneficiaries with low incomes would have Medicare premium and cost-sharing subsidized, just as workers and non-workers receive subsidies for the recommended public or private coverage. These beneficiaries would, of course, benefit from the other Medicare and Medigap changes recommended here.

42. This discussion is taken from Diane Rowland, "Fewer Resources, Greater Burdens: Medical Care Coverage for Low-Income Elderly People," in Pepper Commission, *A Call for Action,* Supplement to the Final Report (Washington, D.C.: GPO, 1990). [Hereafter cited as Rowland, "Fewer Resources."]

43. Under current law, people with incomes below the poverty level are eligible for subsidies through Medicaid. These individuals would benefit from this recommendation as the coverage shifts away from a welfare program and outreach efforts encourage full participation.

44. See above, discussion of minimum benefit package.

45. Estimates for mammogram are based on cost estimates prepared for the Congressional Budget Office for the Medicare Catastrophic Coverage Act. Staff estimates for colorectal screening assume limited screening, consistent with guidelines recommended by the U.S. Prevention Services Task Force, *Guide to Clinical Preventive Services* and use of the fecal occult blood test. Over time, testing may produce increased costs for already covered services, as problems are detected and additional diagnostic testing or treatment is provided. No additional cost estimate is provided for screening for prostate cancer (a digital rectal examination) as the Commission recognizes its inclusion in otherwise covered office visits for the at-risk population.

46. Rowland, "Fewer Resources."

47. General Accounting Office, *Medigap Insurance: Law has Increased Protection Against Substandard and Overpriced Policies* (Washington, D.C.: GAO/HRD 87–8, October 1986).

48. Ibid.

49. Consumers' Union, *Health Insurance Counseling Programs for Senior Citizens: A Survey* (Washington, D.C., May 1990).

50. Ibid.

51. U.S. Congress, Senate Finance Committee, *Catastrophic Care: Excess Revenues,* testimony of Michael Zimmerman, General Accounting Office, 101st Cong., 1st Sess., 1989, S. Hrg. 101–519.

52. Ibid.

53. As in the case of health insurance for these under 65, the Commission recognizes concerns of insurers about adverse selection, since there is no requirement that all Medicare beneficiaries purchase Medigap coverage. It may be appropriate to allow a limited waiting period for coverage of pre-existing conditions for people who in the previous period did not have Medigap protection, whether because they just became Medicare-eligible or because they chose not to obtain coverage.

Chapter 3

Why Do We Need Long-Term Care Reform?

Chapter 3

Why Do We Need Long-Term Care Reform?

Between 9 million and 11 million Americans of all ages are chronically disabled and must depend on others for help in the basic tasks of daily living that we call long-term care. As many as 4 million people are so severely disabled they cannot survive without substantial help. Millions more know the physical, emotional, and financial burdens of caring for relatives or friends who need such care—a mother with Alzheimer's disease, a child with cerebral palsy, a husband paralyzed from an automobile accident. Eight out of 10 American voters are personally familiar with the struggle to obtain and pay for long-term care—in their own families, through close personal friends, or because someone close to them will probably need such care within the next five years.[1]

Yet in contrast to health care—for which most Americans have insurance even if inadequate—there is almost no long-term care insurance for in-home or nursing home care. The individuals who need this care and their families bear most of the burden out of their own resources. Public support comes primarily from the welfare-based Medicaid program, which covers nursing home care only *after* people have exhausted all their resources. But Medicaid provides very little coverage for care in the home. Medicare, which covers health care for the elderly and some of the disabled, is prohibited by statute from covering the basic or custodial services that constitute the bulk of long-term care services. Private long-term care insurance, only now beginning to emerge, covers very few of today's elderly and is simply unavailable for people who are already disabled.

As more and more people come to need long-term care, the woeful inadequacy of coverage becomes increasingly apparent. America, like many other industrialized nations, has witnessed tremendous growth in its population age 65 and over—growth that has been most pronounced among those 85 and over, the group with the greatest potential need for long-term care. In addition to the "graying" of America, improved medical technologies, including better neonatal and trauma care, have helped extend the lives of many young as well as elderly disabled persons.

ERIC FUTRAN

As many as a million children need long-term care; one out of three disabled people are under 65.

Private insurance may expand to assist many of these people. But even optimistic projections indicate that private insurance will fail to reach most Americans, including most of the elderly, even decades into the 21st century, and may not significantly alleviate the need for public support.

Without a change in the nation's approach to long-term care coverage, more and more Americans will have to struggle to find and finance care at home, and will face the specter of impoverishment, especially if they need nursing home care.

To provide the blueprint for a new approach, the Commission assessed the growing problem of inadequate financing for long-term care. It explored the nature of long-term care and the kinds of people who need this care. It then examined how people get and pay for long-term care today, focusing in particular on the limits to public programs. Finally, it explored the potential of private insurance to meet future needs and identified likely gaps in service and protection as the population ages.

WHAT IS LONG-TERM CARE?

Long-term care refers to an array of services needed by individuals who have lost some capacity for independence because of a chronic illness or condition. Long-term care consists of assistance with basic activities and routines of daily living such as bathing, dressing, meal preparation, and housekeeping. It may also include skilled and therapeutic care for the treatment and management of chronic conditions. Services can be provided in a variety of settings—the individual's home, the community, or an institution.

The long-term care population includes people with a wide range of diagnoses and medical conditions. Regardless of diagnosis, need for long-term care can be measured by assessing limitations in an individual's capacity to manage tasks of daily living. These capacities encompass basic human functions that people do habitually and universally (called activities of daily

"If you're a young person with chronic illness [and] need long-term care, there is no program in place," Marilyn Rubin told the Commission. Her 42-year-old husband Bill has multiple sclerosis. His experience characterizes the many obstacles faced by Americans under 65 who need such care.

SHERRY PETERS/THE HARTFORD COURANT

Marilyn and Bill Rubin discovered that, for the working-age disabled, help is hard to find.

The Rubins and their two teenagers live in West Hartford, Connecticut. First diagnosed 24 years ago, Mr. Rubin had no symptoms until long afterward. In 1981, MS forced him to leave work. His condition has deteriorated dramatically since then; today he is a paraplegic.

Since MS is a degenerative disease, Mr. Rubin's health will continue to worsen. This led his neurologist to suggest that they look into nursing home care. But the Rubins encountered a lot of resistance from some homes, partly because Mr. Rubin is much younger than most of the residents—but also because his condition will eventually require intensive, round-the-clock care.

As an alternative, several nursing home directors suggested Connecticut's Prescreening Admission Program. Under it, a medical professional (usually a nurse) and a social worker visit patients' homes to assess their needs. They arrange aide services to help the family care for the patient at home. This seemed to be the perfect solution to the Rubins. But there was one major obstacle: to be eligible, you must be 65.

Mrs. Rubin doubts her husband will survive more than another 10 years. "We need help now, so that we can enjoy these last years. You know there is so much divorce out there. . . . Here are four people who really want to stay together, but there is no agency or program to help people like us," she testified.

living, or ADLs). These include eating, getting in or out of bed or chair, toileting, bathing, and dressing.[2] They also encompass activities necessary to remain independent (known as instrumental activities of daily living, or IADLs). These include housework and laundry, meal preparation, grocery shopping and transportation, financial management, taking medication, and telephoning.[3]

When people are unable to perform these activities, they need help—from other people, mechanical devices, or both.

Inability to perform these activities may result from congenital diseases or trauma. But ADL and IADL limitations are associated more often with chronic conditions ranging from cerebrovascular and cardiovascular disease, to Alzheimer's disease, to organic brain syndrome. Measures of ADL and IADL limitations are particularly useful indicators of the need for long-term care for two reasons. They are not tied to specific diagnoses. And they help predict admission to a nursing home, use of home care, use of hospital services, whether someone can live alone or not, overall Medicare expenditures, and mortality.[4]

WHO NEEDS LONG-TERM CARE?

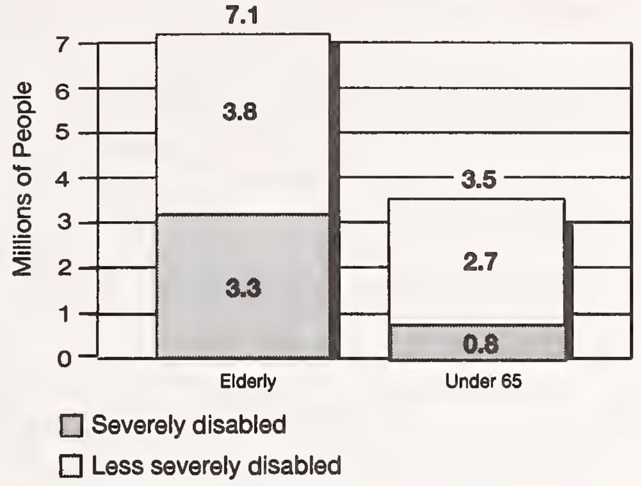
People often think that only older people need long-term care. It is true that elderly persons are more likely to suffer from chronic conditions that require such care. But recent data suggest that between 9 million and 11 million Americans of *all* ages—one in 20 Americans—require assistance with one or more ADLs or IADLs.[5] Two-thirds of the long-term care population are elderly persons living in the community or nursing homes. The remaining one-third are under age 65, most of whom live in the community.

The People

Almost one-quarter of the nation's elderly population—7 million people—are limited in ADLs or IADLs.[6] Disabilities most often result from strokes or from chronic illnesses—like heart disease, Alzheimer's or related dementias, and osteoporosis—that affect primarily the elderly. At the same time, over 3 million people under age 65 are similarly disabled.[7] The reasons for younger people's disabilities vary. Some have congenital or developmental conditions such as cerebral palsy or mental retardation; others are disabled from traumatic accidents or the onset of chronic conditions such as multiple sclerosis (see Figure 3–1).

These estimates inadequately measure the need for long-term care among young children because ADL and IADL limitations are not appropriate measures of their disabilities. Data suggest that as many as 1 million children suffer from chronic illnesses that necessitate long-term care, although only a portion need as much care as adults with ADL impairments.[8] The Office of Technology Assessment recently estimated that an important subset of chronically disabled children depend on life-sustaining medical technology. The number of children considered to be technology-dependent depends on the definition. The number is under 17,000 when limited to ventilator assistance, prolonged intravenous drugs, or other device-based respiratory or nutritional support. It increases to over 45,000 when other technologies such as apnea monitoring or renal dialysis are included.[9]

Figure 3-1 People Needing Long-Term Care, Including the Severely Disabled, by Age



SOURCE: Lewin/ICF estimates using Brookings/ICF Long-Term Care Financing Model and 1987 National Medical Expenditure Survey.

The extent of need among the long-term care population varies. Some require no more than help with financial management or transportation; others are unable to go to the toilet, get out of bed, or eat without help. In this report, the Commission considers individuals severely disabled if they need personal assistance with at least three out of five ADLs (bathing, dressing, toileting, getting in or out of bed/chair, eating) or require substantial supervision due to cognitive impairment or disruptive and dangerous behaviors that impede function. According to the Commission's definition, 4.1 million people are estimated to be severely disabled—3.3 million elderly and 0.8 million under the age of 65.

Where People Live

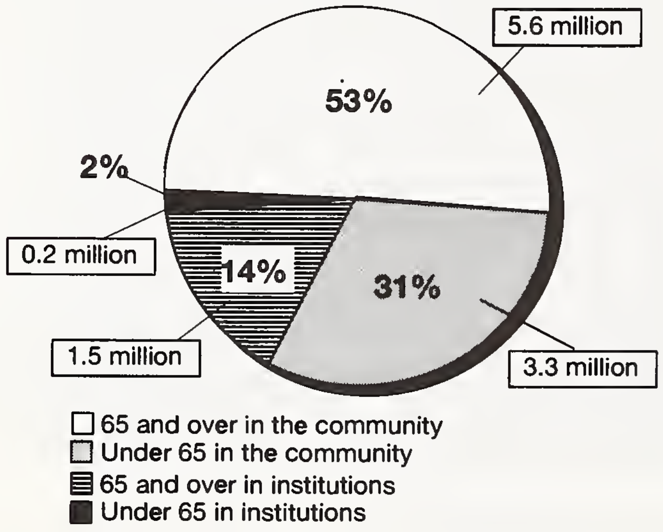
The vast majority of people of all ages who need long-term care live in the community. About 5.6 million elderly and 3.3 million younger people with ADL and/or IADL limitations live at home (or in non-nursing residences). Close to 2 million people live in nursing homes—1.5 million elderly and 0.2 million people under age 65 (see Figure 3-2).

Even among the severely disabled, more people live at home than in nursing homes. About 2.4 million Americans are severely disabled and living in the community, compared with 1.7 million who are nursing home residents, most of whom meet the Commission's definition of severely disabled (see Figure 3-3).

Elderly people are the primary users of nursing homes. Nine out of 10 nursing home residents are elderly; almost half are over age 85. On any given day, 5 percent of the elderly are in nursing homes.[10] Point in time estimates, however, obscure the real risk of nursing home use for older people. Among people turning age 65 in 1990, estimates are that 36 to 45 percent will use a nursing home before they die.[11] Women have a much higher risk than men; more than half are likely to spend time in a nursing home compared with only one-third of men.[12]

A minority of 65 year olds (about one in five) can expect to receive a year or more of nursing home care over their lifetimes.[13] However, many nursing home users do not end their lives in nursing homes after long stays. Between 26 percent and 45 percent of nursing home stays last less than three months, and half these "short-stayers" are able to return to their homes.[14, 15]

Figure 3-2 Residence of People Needing Long-Term Care



SOURCE: Lewin/ICF estimates using the Brookings/ICF Long-Term Care Financing Model.

EARL DOTTER

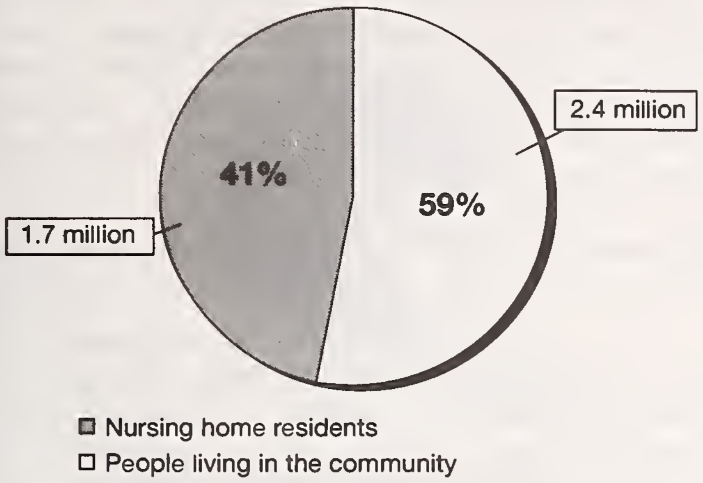
Arthritis and other severely disabling conditions force 4.1 million Americans to depend on others for basic care.

HOW PEOPLE GET AND PAY FOR CARE

In 1988 the nation spent $53 billion on long-term care (see Table 3-1). Only 18 percent of those expenditures went to home care—despite the fact that four out of five disabled and almost three out of five severely disabled live at home (see Figure 3-4). People at home depend overwhelmingly on their family and friends to provide care, frequently at enormous physical and emotional cost. When they want to buy care, they may have trouble finding it and must bear its full expense. Public programs provide little help for long-term care in the home or community.

Public spending on nursing home care, by contrast, is substantial. In fact, total spending on nursing home care ($43.1 billion in 1988) is split about evenly between the public and private sectors (see Figure 3-5). Few would call this an equitable partnership, however, because so much of the private share is fully paid for, without the benefit of insurance, by the individuals and families who need the care. Private insurance pays only 1 percent of nursing home care. People in these circumstances are, in effect, financing the care out of accumulated savings (and, to some extent, current income). Some argue that the key to a long-term care solution is the encouragement of greater savings to cover the cost of future long-term care catastrophe. Yet given the very high cost of a nursing home stay and the inability to predict whether such stays will occur (or how long they will last), private savings are an inefficient way to cover these expenses. Most people will either save too much or not nearly enough.

Figure 3-3 Residence of the Severely Disabled



SOURCE: Lewin/ICF estimates using the Brookings/ICF Long-Term Care Financing Model.

Traditionally, our society has relied on risk-spreading mechanisms—insurance, private or public—as the appropriate way to pay for events like these.

In long-term care, no real system exists for sharing the risk, which is the fundamental objective of insurance. Most public support for nursing home care is available only *after* people experience financial catastrophe. Unlike insurance, this support does not protect resources when a disaster takes place. Consequently, most people who need nursing home care—even for a relatively short stay—face the risk of impoverishment.

Caring for People at Home

Almost three-quarters of severely disabled elders receiving long-term care at home or in the community in 1989 relied solely on family members or other unpaid help (see Figure 3-6). Two-thirds of people who needed assistance in all activities of daily living received no paid assistance.[16]

Informal Care—More than 7 million spouses, adult children, other relatives, friends, and neighbors provided unpaid assistance to disabled elders in 1984 (see Figure 3-7).[17] There are no comparable national data on caregivers to nonelderly disabled people, but anecdotal information suggests that families also assume the majority of the care for relatives under age 65.

Nor is this simply occasional care. Seven out of 10 informal caregivers—family members and friends—bear the major responsibility for the care of disabled elders, and one out of three is a sole provider.[18] Eight out of 10 caregivers provide unpaid assistance averaging four hours a day, seven days a week.

The burden of care falls overwhelmingly on the shoulders of women—three-quarters of informal caregivers are female. Since one-quarter of these caregivers are ages 65 to 74 and another 10 percent age 75 or older, many of these caregivers are themselves vulnerable.

A large proportion of caregivers are financially disadvantaged. One-third report family incomes in the poor or near-poor category, and both female and male caregivers are more likely to report family incomes below the poverty line than people of the same age with no caregiving responsibilities.

One in three caregivers is in relatively poor health. Among spousal caregivers the proportion is even

Table 3-1 National Long-Term Care Expenditures, by Source, 1988

(Dollars in Billions)

Nursing Home Care	
Source of spending	
Medicaid	$19.2
Medicare	0.8
Other federal	1.0
Other state	.1
Out-of-pocket payments	20.8
Private insurers and private organizations	1.3
Total	$43.1 *

Home Care	
Source of spending	
Medicaid	$3.3
Medicare	2.6
Other federal programs	0.6
State	0.5
Out-of-pocket payments	2.1
Private insurers and private organizations	.6
Total	$9.7
Total long-term care expenditures	$52.8

* Numbers do not total due to rounding.

SOURCE: Health Care Financing Administration, Office of the Actuary, and Commission staff analysis of unpublished HCFA data.

higher, with more than four out of 10 of the wives and over half of the husbands reporting fair to poor health.

The direct emotional, physical, and financial burdens associated with caring for a disabled elderly family member or friend are not the only costs, heavy though these burdens are. Additional costs include lost opportunities that caregivers must forego. In particular, the competing demands of employment and caregiving may result in real, although sometimes hidden, costs to caregivers, employers, and society. Caregivers who reduce their work hours, take time off without pay, or quit their jobs because of elder care responsibilities experience financial losses in earnings and job-related benefits—in addition to the emotional costs of juggling work and care obligations or forgoing the satisfaction of working.

Financial strain isn't the only cost of long-term care. Families coping with a loved one suffering from chronic illness and disability must deal with emotional stress as well. The story of Charles Keeney, an auto parts dealer from Charleston, West Virginia, illustrates that.

JOHN FERGUSON

Three generations of Keeneys—Jason, his grandfather, and his father Charles—share the emotional and financial hardships of long-term care.

Two years ago, his father was diagnosed with Alzheimer's disease, Mr. Keeney told the Commission. Although his elderly mother provided much of her husband's care, Mr. Keeney often drove 35 miles to their home to help out. But after his father suffered a minor stroke, they realized the inadequacy of their caregiving arrangements.

So when the Keeney's neighbors decided to move, Mr. Keeney bought their house for his parents. This helped him care for his father, but forced Mr. Keeney to take out four mortgages on his own home. Although his wife also works, and his parents have a modest income, it's not enough to cover care for Mr. Keeney's father. Medication alone runs $150 a month.

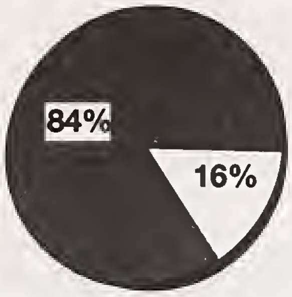
Shouldering the financial needs of his own family and those of his parents is tough. It's caused the Keeneys to change their lifestyle and future plans. They used to take great pleasure in vacations and other family activities. These things are now out of the question. They hoped to send their son Jason to college and set aside money from Mrs. Keeney's salary for his tuition. But now these savings must go for his grandfather's care.

"My mother and father both worked hard all their lives, and went through the Depression," Mr. Keeney told the Commission. "They are proud people. Yet just the other day, my mother said she was worried about not being left with enough money to have a proper burial."

"It is hard enough dealing with my father's disease on an emotional level," he added. "It should not also cause the anguish of financial disaster."

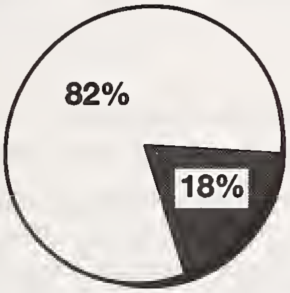
Figure 3-4 People Needing Long-Term Care and Expenditures for Long-Term Care, by Place of Residence

Persons Needing Long-Term Care, 1990



Total Population: 10.6 Million
■ Living at home ☐ In nursing home

Expenditures on Long-Term Care, 1988



Total Expenditures: $52.8 Billion
■ Home care ☐ Nursing home care

SOURCE: Health Care Financing Administration, Office of the Actuary, and Commission staff analysis of unpublished HCFA data.

More than one in 10 of all caregivers reports leaving his or her job to assume caregiver responsibilities; many others turn down job opportunities or promotions because of caregiving demands. Among the 30 percent of caregivers who have a job, many alter their work schedules to accommodate care demands. One out of five employed caregivers, for example, cuts back on hours, almost one in three rearranges a schedule, and almost one in five takes time off without pay. Women are much more likely than men to change their work schedules in order to assume care tasks at home.

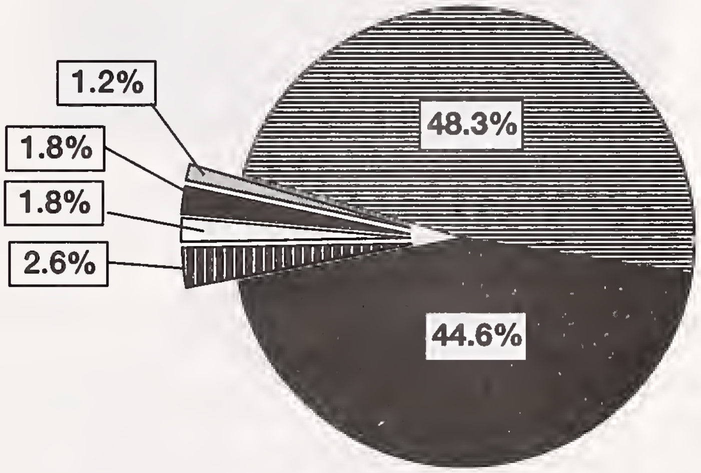
Employers, government, and society also pay costs because of the informal care burden. Employers face the costs of decreased productivity due to tardiness, absenteeism, and poor morale, plus the costs of replacing valued employees. Government and societal costs include reductions in GNP, forgone income tax revenue, and increased public expenditures to support caregivers with reduced incomes, nonwage compensation such as health insurance, and future retirement benefits.

Purchasing Care—That families devote such effort to caring for disabled relatives is moving testimony to the strength of the human spirit. But the scale of their sacrifice suggests that there may be objective barriers to purchasing help. For the minority who purchase long-term care services in the home costs can be substantial, especially for the severely disabled. Monthly payments averaged $439 for the most severely impaired purchasers and $88 for people with limited impairments in 1982. Furthermore, the median income of people who spent the most on home care in 1982 ($136 per month or more) was more than twice the median income of people who spent the least (less than $15 per month)—suggesting that affordability is a barrier.[19]

Costs and affordability are not the only barriers, however. The difficulty of finding quality care is another. Family members may be understandably reluctant to "abandon" a loved one to the care of strangers. And their reluctance is almost certainly reinforced by difficulty in finding the services they need and doubts about the quality of those services if they find them. In the absence of public programs or a substantial private market, mechanisms to assist families find appropriate care and to deliver and monitor that care do not exist in many places. For the most part, families are on their own.

Public Programs—In 1988, federal and state governments spent about $7 billion on in-home services—about 37 percent through Medicare, 47 percent through Medicaid, and 16 percent through federal grant or state-funded programs. The programs differ in significant ways, but all are limited in their capacity to finance long-term care.

Figure 3-5 Sources of Payment for Nursing Home Care, 1988



Total Spending: $43.1 Billion

▤ Direct consumer payments ☐ Medicare
■ Medicaid ■ Other private
▥ Other public ▨ Private health insurance

NOTE: Numbers do not add to 100 percent due to rounding.
SOURCE: Health Care Financing Administration, Office of the Actuary, In HHS News, May 3, 1990, Table 3.

The decision to put an aged parent in a nursing home is emotionally wrenching. A Los Angeles couple, Jim and Rebecca Schienle, described their personal ordeal for the Commission. Mr. Schienle's mother Lorraine, afflicted with Alzheimer's disease, had lived with the family for over a year before they reluctantly put her in a nursing home. "[W]e were in a totally impossible situation," Mrs. Schienle testified. "Emotionally we had the desire to keep her at home, but financially and physically it was completely impossible."

JEFF LIBMAN

Without outside support at home, Jim Schienle had no choice but to place his mother Lorraine in a nursing home.

The Schienles had done everything possible to provide for his mother. They restructured their house, moving their teenage sons to a den to accommodate her, and lost Mrs. Schienle's income when she quit work to care for her mother-in-law. The reduced family income, coupled with care-related expenses, nearly cost the Schienles their home. To worsen matters, the family couldn't handle Lorraine Schienle's growing needs.

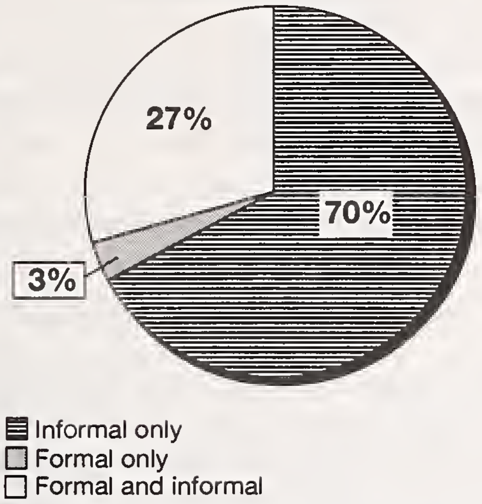
Without government programs to support home care, the Schienles felt the only option was a nearby, well-run nursing home. But like many adult children facing this tough decision, they question whether they did the right thing. Mr. Schienle spoke of the tremendous guilt he experienced long after admitting her. He wonders if he failed to reciprocate for the care she gave him while he was growing up. His wife told the Commission, "I'm still really angry about having to put her in the nursing home, but I don't know who to blame. Did we fail her? Did you fail her? Did the government fail her?"

Despite the hardships, the Schienles agreed they would bring his mother home if their financial picture improved. Mr. Schienle lamented the lack of home care and adult day care assistance. They should be available, he said, so that "when other families are confronted with the problem of caring for their parents, their decision will be less traumatic . . . they will feel less helpless because they have real choices."

Medicare—Medicare is a major payer for in-home care. It is an entitlement program, requiring it to provide covered in-home services to all persons who satisfy eligibility requirements. Eligibility, however, is limited to people who are unable to leave their homes (homebound) and who require skilled or professional service. Medicare covers personal care only when skilled services are required. This restriction is consistent with Medicare's statutory requirement prohibiting coverage of custodial care. But it means that most disabled elderly are not eligible for benefits and, if they are eligible, are unlikely to receive benefits of sufficient scope or duration to address their needs.[20]

Over the years, Medicare has been criticized for inconsistent and excessively stringent interpretation of eligibility criteria, and Congress has clarified those criteria to broaden coverage. The focus on skilled care remains, however. Without legislation specifically authorizing coverage of personal care regard-

Figure 3-6 Source of Home Care Services for the Severely Disabled Elderly Population, 1989



SOURCE: Lewin/ICF and the Brookings Institution, 1989 estimates based on National Long-Term Care Survey, 1982

less of a person's skilled care needs, the Medicare home-care benefit is characterized more appropriately as an extended health or acute care benefit than as long-term assistance for those who are chronically disabled.

Medicaid and Other State Programs—States provide long-term care through the Medicaid program, federal grants, and their own funds. A survey of state spending on in-home and community care for the elderly in 1986 reveals the tremendous variation across states in long-term care spending.[21] The seven states with the highest expenditures on home and community-based care spent more than $100 per elderly person, in contrast to the seven states with the lowest expenditures, for which the comparable figure was less than $20. Five states, with 30 percent of the nation's elderly, accounted for 60 percent of total spending on in-home and community care for the elderly.[22]

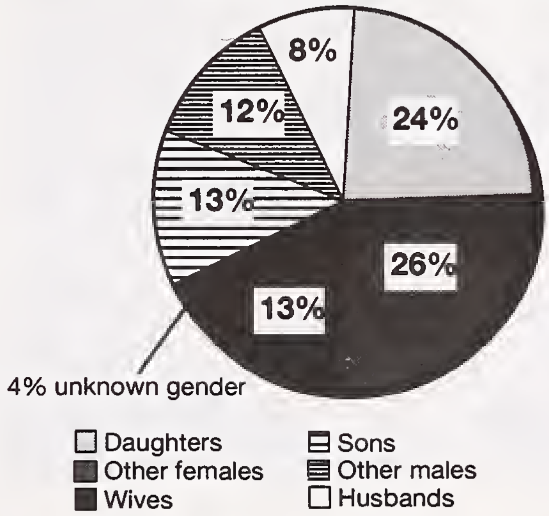
Funding sources also vary widely, according to the same survey, even among the highest-spending states.[23] Some rely heavily on Medicaid financing, some on federal block grants, and some on their own funds. From the states' perspective, all sources have pluses and minuses. Medicaid offers the potential to share financing with the federal government. But Medicaid is an open-ended entitlement program, which must provide any covered service to all who satisfy its income and disability requirements. The state share of Medicaid spending can, therefore, be substantial. Furthermore, Medicaid regulations impose requirements for program design and operation (like physician certification or nurse supervision of personal services) that some states find overly medical. Grants to states for social services and state funds allow states greater flexibility in designing long-term care services, but funding from these sources is considerably more limited.

Medicaid finances in-home care to low-income people who qualify through two regular mechanisms—a home health benefit that the federal government requires all states to offer and a personal care benefit that states are permitted but not required to offer.

Few states rely on Medicaid's home health benefit to provide custodial care in the home. Although states are required to offer it, they are permitted discretion to set amount, duration, and scope of services; payment rates for providers; and eligibility requirements. This discretion has been used to keep Medicaid expenditures on the home health benefit low. The Medicaid personal care option, which relies upon individuals rather than home health agencies to deliver personal care, subject to physician authorization and nurse supervision, is offered by only half the states. New York—the state with the highest in-home expenditures per elderly·person—accounts for the vast majority of personal care and home health spending, with the remaining personal care funds concentrated in a handful of states.[24]

Medicaid spending on home care through these two benefits is only about 10 percent of its spending on nursing home care. To promote more extensive investment in home care, section 2176 of the Omnibus

Figure 3-7 Informal Caregivers of Disabled Elderly in the Community, 1984*



*Disabled elderly are those needing human help with activities of daily living or instrumental activities of daily living.

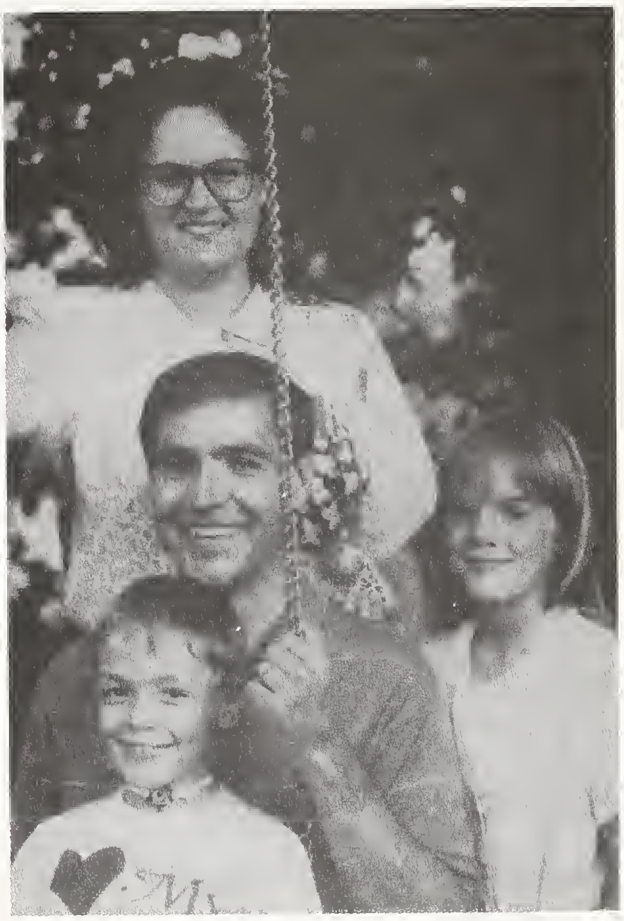
SOURCE: Robyn I. Stone and Peter Kemper, "Spouses and Children of Disabled Elders: How Large a Constituency for Long-Term Care Reform?", *The Milbank Quarterly* 67 (3-4, 1989): Unpublished Appendix.

Budget Reconciliation Act of 1981 authorized a waiver of Medicaid requirements to allow states to provide a broad array of in-home services. The waiver authority permits states to liberalize some income standards to broaden coverage, but limits potential cost increases by allowing states to restrict eligibility to specific geographic areas and population groups. In return for the waivers, states are required to keep Medicaid expenditures on long-term care and the total numbers of people served under the waiver within the levels that would have been attained had the waivers not been granted.

As of February 1988, 42 states had a total of 86 regular section 2176 programs. Of these 86 programs, 42 served the aged and disabled, 35 the developmen-

Deborah and Scott Russell, parents of health-impaired twins, face an endless nightmare of financing long-term care. They find the health care financing system totally unworkable.

Now seven years old, the twins' premature birth resulted in serious health problems. While Meg's congenital heart defect has been corrected, life-threatening difficulties with Dan's air passage persist. The child spent five months in neonatal intensive care units, and has had more than 30 operations. He will soon undergo major surgery to resolve his problem, but until then must be monitored around-the-clock. Dan's family provides much of his care; nonetheless, his average annual medical costs are a staggering $200,000.


BRADLEY S. PINES

Neither public nor private insurance provides stable support for the Russell family in caring for their disabled child at home.

Private insurance, along with crippled children's and Medicaid waiver programs, has covered Dan over the years. Yet regardless of who is paying, the Russells must continuously fight for the home care their son's doctors have prescribed. In Mrs. Russell's words, "The payers who authorize care seem to feel that if our family is not in crisis, we must be getting too much home care. After seven years, we know we can't live on the edge like that."

Dan is now on an insurance policy through his father's job, but the $500,000 lifetime limit is nearly exhausted. Despite the Russell's constant vigilance over their son's needs and their ongoing efforts to secure private insurance for him, the task is overwhelming.

The Russells are blessed with working for understanding employers who provide flexible benefits, and fortunate enough to live in Michigan—a state that offers a wide range of human services. Nevertheless, Mr. Russell told the Commission, "we as sophisticated and motivated consumers have found the health care financing system totally unworkable. How much worse it must be for families who love their child just as much as we love ours, but lack our advantages. It doesn't seem right that these children should not be given the opportunity to live and thrive within their families."

tally disabled and mentally retarded, and three served both groups. Four programs served persons with AIDS and related conditions, one served chronically ill children, and one served the mentally ill. These programs however, served only 79,000 aged or disabled persons and 27,000 developmentally disabled or chronically mentally ill persons in fiscal year 1986.[25]

One reason for the limited scope of the programs may be state spending constraints. But another major reason is that states have had difficulty meeting the federal limits on spending and numbers served.

The limits assume that broader home care coverage would in fact save money because it would allow some who are now receiving expensive care in nursing homes to be taken care of less expensively at home. As a substantial body of demonstration experience now attests, however, broader home care coverage does not in fact produce this result.[26] Although availability of home care may allow some people to remain at home who would otherwise require nursing home care, many who could appropriately be in nursing homes are, in fact, at home. These people legitimately qualify for home care when it is offered, thus increasing total long-term care spending and total persons served. The problem is particularly acute in states that have imposed limits on nursing home bed construction, because shortages of nursing home beds increase the number of severely disabled individuals in the community who desperately need long-term care.[27]

In light of the difficulty of meeting the stringent federal requirements that prohibit increased spending but also prohibit service to a larger number of people than would have been served without the waiver, state waiver programs are likely to remain quite small. The Congress recently enacted new waiver authority that would eliminate the constraint on numbers served if states agree to accept a cap on their overall Medicaid funds for nursing home care as well as home care. This change at least allows the possibility of serving more people if real nursing home savings can be achieved, but it exposes states to considerable financial risk. To date only Oregon has opted to use the new waiver authority.[28]

Disabled children can be served under the standard 2176 waiver program. HCFA also created a separate category of 2176 waivers called "model waivers" to deal with an eligibility problem faced primarily by children.[29] Many disabled children living in the community do not qualify for Medicaid because the income and resources of their parents are deemed to be available to them if they are living in the same household. Conversely, if the same child is institutionalized, after the first month away from home only the child's financial resources are deemed to be available to pay for care. The model waiver allows a state to waive the deeming rules and to pay for support services to help keep children at home. Although the Secretary of HHS cannot limit this program to fewer than 200 persons, states may impose lower limits. Seventeen states had a total of 20 model waiver programs as of February 1988.

States also have the option, as a result of a change included in the Tax Equity and Fiscal Responsibility Act of 1982, to extend Medicaid eligibility to certain disabled children who would otherwise be eligible only if they lived in an institution. The state must determine that these children require the level of long-term care provided in an institution, and that their needs can be met appropriately and at no greater cost at home. States electing this option also are required to cover on a statewide basis all disabled children meeting these criteria. This program serves only a fraction of chronically disabled children. The 22 states that reported use of this approach in 1988 served a total of only 585 children across the country through this option.[30]

The flexibility afforded by the waiver and optional home care programs generally only benefits children in need of substantial nursing or other types of medically oriented care, since they are the children most likely to receive care in an institution.

Besides Medicaid, two federal social service programs also authorize a broad range of in-home and community-based long-term care services—the Social Services Block Grant Program (SSBG) under Title XX of the Social Security Act and the Older Americans Act. Under these programs, all states support in-home and community-based long-term care services.[31] These programs do not carry nearly as stringent restrictions on eligibility and on the scope of services to be provided as do Medicare and Medicaid. But their ability to provide significant funding for in-home and community-based care, especially compared with total federal expenditures devoted to institutional care, is extremely limited.

States receive allotments of Title XX funds on the basis of the state's population, within a federal expenditure ceiling. States define eligibility groups, and services are generally though not always limited to those with low incomes. Because Title XX provides a variety of social services to diverse population groups—including families with children as well as the elderly and disabled—competition for funds is intense. In addition to providing in-home and community-based long-term care services to the elderly and disabled, for example, Title XX is one of the major federal programs supporting child day care. Its funding has also declined in real terms since 1980, intensifying the competition for funds.

The Older Americans Act gives authority for a wide range of in-home and community-based services to be provided to older persons with the greatest social or economic need. Specific individual means tests are prohibited, but like Title XX, the Act's ability to provide significant funding for long-term care is limited because it is less well-funded than other programs. While the Older Americans Act is the major vehicle for the delivery of social services to the elderly, most of its funding is devoted to support for nutrition services (congregate meals and home-delivered meals).[32]

A few states are investing substantial resources of their own in designing innovative in-home and community services programs. According to a 1986 survey, states relying heavily on their own resources are among states that devote the most resources to in-home care.[33] These states are also investing considerable effort in designing programs that can extend eligibility beyond the poorest elderly and use management techniques to keep costs within reasonable bounds. Such techniques include targeting of benefits to the severely disabled; relying on case managers to develop individual care plans and authorize services; and limiting expenditure amounts case managers can authorize, either overall or for individual recipients. Spending limits are typically tied to the cost of nursing home care.[34]

Program administrators believe these mechanisms allow them to provide support for disabled people at home without reducing the amount of care provided by family members. Although these programs have not been formally evaluated, administrators' perceptions are consistent with demonstration experience.

An evaluation of the National Channeling Demonstration, for example, found only modest reductions in informal caregiving when subsidized home and community-based care services were provided, primarily in IADL help such as housework and transportation.[35] These reductions, moreover, were not due to the withdrawal of primary caregivers, but rather withdrawal by friends and neighbors who were providing additional support. A more recent study of the impact of community care on the provision of informal care to homebound elderly persons concluded that formal care supplemented the efforts of informal caregivers rather than supplanting them, and that informal caregiving remained stable over time.[36]

> ***"This country has been known as the land of the demonstration project. We are turned to by all the world for good experiments. Unfortunately we have no programs."***
>
> ***—Dr. Robert Kane, dean, School of Public Health, University of Minnesota***

These initiatives may provide models for broader coverage of care for disabled people at home. However, they represent the exception, not the norm, in the nation's provision of home and community-based care. Public dollars for these services are limited in most areas of the nation. Unless they need skilled care (and qualify for Medicare), or are poor *and* in a generous state, frail elderly and disabled Americans of all ages must depend on their own resources and on relatives and friends to provide the care they need.

Nursing Home Care

Despite the enormous efforts of disabled individuals and their families to manage at home, sometimes nursing home care becomes inevitable. At that point, individuals and families face not only emotional but also financial devastation. At an average cost of about $85 per day, even a short stay in a nursing home absorbs substantial resources. At over $2,500 per month, the cost of a nursing home stay exceeds monthly income from Social Security, pensions, and assets for four out of five elderly people.[37] Long stays can exhaust the savings of a lifetime. Among the elderly, in fact, nursing home expenditures are the primary source of catastrophic expenses. For older people with out-of-pocket spending of $3,000 or more, 83 percent goes for nursing home care (see Figure 3–8).[38]

This pattern reflects the absence of private insurance or public programs to protect people against the costs of nursing home care. Medicare protects the elderly and some nonelderly disabled people against financial loss when they need hospital or physician care; but does little to help with nursing home costs. Medicaid is the primary source of nursing home financing but it does not protect people from impoverishment; it finances their care only when impoverishment occurs. Nor does it guarantee care of an acceptable standard. Medicaid, like other programs for the impoverished, is subject to budgetary constraints that can jeopardize access to quality care.

Medicare—Medicare benefits include up to 100 days of nursing home care, but only for people who require skilled nursing or rehabilitative care following a hospital stay—an intensive level of service that accounts for only a very small proportion of all nursing home care. Furthermore, cost sharing, which begins on the twenty-first day of a Medicare stay, is not tied to nursing home costs. Rather, it is set at one-eighth the cost of the Medicare hospital deductible.[39] At $74 per day in 1990, cost sharing in many parts of the country exceeds the cost of nursing home care. In these circumstances, even people who satisfy coverage criteria will not actually receive any benefits.

Historically, Medicare has financed only about 2 percent of the nation's nursing home care. Although recent regulatory changes produced a 40 percent increase in Medicare spending, Medicare's share of nursing home expenditures remains negligible.[40] Only one in three elderly people entering nursing homes satisfies Medicare's eligibility requirements. Even among short stayers, less than half (45 percent) qualify for any benefit.[41]

Not only does Medicare cover a limited proportion of nursing home entrants, it often fails to cover a substantial proportion of nursing home care even for those who receive benefits. An estimated 75 percent of people who receive Medicare remain in a nursing home after the 20 days of full coverage.[42]

In sum, Medicare's role in nursing home care, as in home care, is more appropriately characterized as fi-

Alzheimer's disease. An extended nursing home stay. Old age and poverty. You read about these conditions all the time. Edrell Trickle of Blytheville, Arkansas, lives with them.

MARK BEVINS/BLYTHEVILLE COURIER

Edrell Trickle has exhausted a life savings caring for her husband, who has Alzheimer's disease.

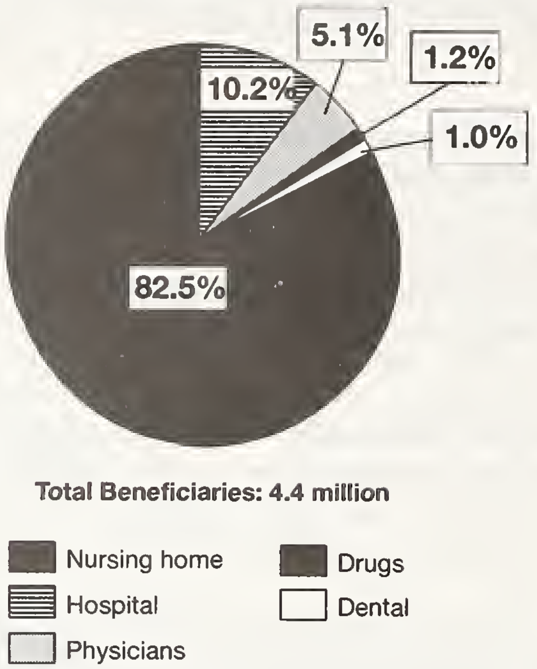
Mrs. Trickle's 86-year-old husband Tobe has Alzheimer's disease and is confined to a nursing home. The couple must endure watching savings from his hard work as a crane operator and mechanic dwindle. In the past year alone, $20,000 went for nursing home care; the past few years have consumed $60,000. Soon all their retirement funds will be exhausted.

Until five years ago, Mrs. Trickle cared for her husband herself. His doctor then recommended a nursing home. A devoted wife, Mrs. Trickle visits Tobe daily. His illness requires considerable financial sacrifices of her as well. She doesn't turn on the air conditioning until the temperature exceeds 90 degrees. Her shoes are over 20 years old. And unless meat has been marked down because the sale date is expiring, she doesn't buy it.

"I save every penny I can to care for Tobe," Mrs. Trickle testified to the Commission. "Just the other day, I wanted ice cream so bad. I saw it in the grocery. But then I thought about Tobe and how bad I might feel if I spent the money on myself. I decided not to buy it."

Once their life savings have disappeared, Mrs. Trickle worries about how she will care for herself. Unfortunately, she is only one of millions of elderly Americans in this position.

Figure 3-8 Distribution of Out-of-Pocket Health and Long-Term Care Costs for Elderly with More Than $3,000 in Direct Expenditures, 1985



SOURCE: Thomas Rice, "The Use, Cost, and Economic Burden of Nursing Home Care in 1985," *Medical Care* 27 (12) (December 1989).

nancing extended medical or acute care than as long-term nursing home care.

Medicaid—Medicaid, the federal/state welfare program that also finances health care for the poor, provides 90 percent of the public financing for nursing home care, and more than 40 percent of *all* nursing home revenues.[43]

Medicaid is a payer of last resort. Disabled people with incomes and resources low enough to qualify for cash welfare assistance under the Supplemental Security Income (SSI) program are eligible for benefits. Others qualify only by spending down their assets and income on the cost of care until they become eligible for Medicaid coverage.

People spend down to Medicaid eligibility in a two-stage process.[44] First, to obtain Medicaid benefits, people's resources or assets (typically excluding the home, at least for a period of time) must be less than a specified amount.[45] In most states, that amount was $2,000 in 1989 for an individual without a spouse, the same level used for SSI program eligibility. Until September 1989, the amount for a person *with* a spouse was $3,000, essentially impoverishing the spouse as well as the nursing home resident. Legislation, described below, has since been passed that provides the spouse significantly better protection.

Second, after they have exhausted virtually all their life's savings to pay for care, individuals must spend down their incomes to receive Medicaid benefits. In 30 states Medicaid pays for care if and when the costs of nursing home care exceed people's ability to pay. People are allowed to keep a small amount ($30 a month, typically) for personal needs and, as described below, some income is protected for spouses at home. All remaining income must be devoted toward the cost of care; Medicaid pays the difference between what people contribute and the nursing home reimbursement rate.

> ***"We don't usually think of it this way, but the Medicaid program for nursing home care is actually an entitlement that has a deductible of one's entire income minus . . . about $30 a month."***
>
> ***—Dr. Rosalie Kane, professor of social work and public health, University of Minnesota***

Twenty states, however, will not cover nursing home care for people whose income exceeds a certain amount, even if that income is less than the cost of this care. The income cutoff is typically set at three times the SSI payment standard (approximately twice the poverty level)—about $1,100 per month in 1989—the maximum allowed by federal law. In these states, disabled people whose incomes are too high to qualify for Medicaid but too low to pay nursing home rates must remain in the community, rely on family and others to cover the balance of the costs of care, or find a nursing home willing to accept what they are able to pay.

Concern that Medicaid spend-down requirements were impoverishing not only nursing home residents but also spouses remaining at home led Congress to liberalize eligibility standards. Provisions in the Medicare Catastrophic Coverage Act of 1988 that remain in effect require states to provide spouses a specified level of asset and income protection when determining amounts that residents must contribute to the costs of care. As of September 1989, spouses could keep a minimum of $12,000 in assets, or half of the couple's total assets, up to a maximum of $60,000. States could raise the minimum spousal protection, up to $60,000; 13 states have done this. Regardless of the minimum, however, any assets above the $60,000 have to be applied to the costs of the resident's care. Spouses are also guaranteed minimum income protection. This protection, which will be fully phased in by July 1992, will allow the spouse of a nursing home resident to retain a monthly income of up to 150 percent of the federal poverty level for a couple (or about $1,000 in 1989). Additional amounts for certain housing expenses could bring total protection to a maximum of $1,500 per month. (These amounts are indexed.)

These changes establish a floor of protection against impoverishment for spouses of nursing home residents. But most nursing home residents (87 percent) are single and must relinquish all their resources and income to receive public benefits.[46] Recent evidence indicates that just over one-third of nursing home users receive Medicaid when they enter the nursing home and another 10 percent to 16 percent spend down their assets to become eligible for Medicaid during their stay. By one estimate, about a quarter of nursing home users spend down to Medicaid eligibility over their lifetimes.[47]

These figures are regarded as low estimates of the proportions who do so, however, because data sources underestimate the people with long stays. Not surprisingly, the likelihood of spending down increases with length of stay. More than three-quarters of people who become sufficiently impoverished to qualify for Medicaid have stays that exceed six months.[48]

Even if they do not spend down to Medicaid, nursing home users face the heart-rending prospect of dissipating the savings of a lifetime. Relying on Medicaid means facing the stigma of dependence on a welfare-based system. Elderly people, in particular, feel demeaned by having to apply for public assistance after they have made sacrifices all their lives in order to maintain their financial independence.

But reliance on a welfare-based system poses problems beyond personal anguish. Eligibility for Medicaid does not guarantee access to care of acceptable quality.

Concern about the quality of care Medicaid recipients receive in nursing homes is longstanding and widespread.[49] Evidence that many nursing homes do not provide adequate quality of care or quality of life led the Congress to enact major reforms in requirements nursing facilities must meet to participate in Medicaid (and Medicare) and in enforcement of those requirements. These initiatives illustrate the importance of federal involvement in and oversight of nursing home policy to protect citizens in all states.

TOM HANAFEE/DAUGHTERS OF CHARITY NATIONAL HEALTH SYSTEM

After lifelong struggles for financial independence, too many elderly people must depend on welfare for long-term care support.

Access to nursing home care, whatever its quality, is also a problem for people who must depend on Medicaid. For nursing home services, as with other services, states have considerable flexibility in setting payment rates for care. As nursing home costs absorbed a growing share of states' spending, states turned to payment controls to keep expenditures in check.[50]

Amounts states pay for nursing home care and the methods they use to determine payment rates vary considerably, affecting the number and nature of nursing homes willing to serve Medicaid patients. State-by-state statistics on Medicaid and private rates are not available. Nationally, however, Medicaid rates are estimated to average 20 percent to 30 percent below private pay rates.[51] Substantial evidence indicates that in these circumstances nursing homes give preference to private pay patients over Medicaid patients. Furthermore, unless states vary payment rates with patient care needs (and only a few do), nursing homes are likely to favor Medicaid patients needing little care over those needing costly and intensive service. Federal law and regulation aim to prevent active discrimination against Medicaid patients. But as long as substantial differentials in payment rates exist, implicitly discriminatory behavior is inevitable.

The more limited the supply of nursing home beds, the more likely it becomes that Medicaid patients will have difficulty obtaining access to care. High occupancy rates and research studies indicate that the demand for nursing home care has long exceeded the supply of nursing home beds.[52] Encouraged by federal law until the mid-1980s, many states made considerable efforts to regulate nursing home construction. Partly due to those efforts, the supply of beds has not kept pace with growth in the elderly population—most importantly, with the particularly rapid growth in the population over age 85, the group most likely to need institutional care. While the number of nursing home beds increased 15.8 percent between 1977 and 1985, the number of beds per elderly person declined.[53] Among the population age 85 and over, the number of beds per 1,000 people declined nearly 14 percent over that period.[54]

As virtually the only protection for people needing nursing home care, Medicaid has played an invaluable role in financing care for the people who need it. But as a welfare-based payer of last resort—financing care only after people have used up everything they have—Medicaid's protection is intrinsically limited. Furthermore, Medicaid's capacity to serve people adequately, even *after* they have exhausted their resources, is a function of states' willingness and ability to pay for nursing home care. Experience raises serious question as to whether that capacity is sufficient to meet people's needs.

THE ROLE OF PRIVATE LONG-TERM CARE INSURANCE

Although private insurance is still an insignificant source of long-term care financing—less than 2 percent—free-standing long-term care insurance has experienced spectacular growth in the last three years. In 1986 fewer than 15 insurers were selling long-term care insurance policies of some type. By the end of 1989, 118 companies (including most of the larger insurance companies) were marketing policies, representing an increase of 12 percent over 1988.[55] Since 1987, the number of policies sold has more than doubled—increasing from 423,000 to more than 1.5 million.[56]

Development of the Market

The market for private long-term care insurance has been slow to emerge.[57] Insurers have been reluctant to offer coverage in the face of considerable risk that premium revenues will be insufficient to cover benefit expenses. Insurers face the risk that only persons likely to use services will buy insurance (adverse selection); and that once insured, people are more likely to use services and will use more services than they would have without the insurance (moral hazard). Equally important, they face considerable uncertainties about future home care and nursing home care prices, disability rates, mortality rates, and nursing home and home care use rates.

These risks are more severe for coverage of long-term care, even though they exist for other types of insurance, for two reasons. Long-term care is more difficult to define and easier to use than health care because it includes personal as well as medically oriented services. Moreover, the need for long-term care may not arise until 20 to 40 years after the policy is purchased.

Recent growth in private long-term care insurance does not mean these risks to insurance have been eliminated. Rather it means that insurers have designed and marketed policies to limit their financial liability in order to protect their solvency.[58] First, insurers do not sell policies to persons who are already disabled. Insurers' efforts to limit their risks, in fact, may lead them to define "disability" in a way that excludes people with health conditions like circulatory disorders or arthritis, regardless of individuals' ability to function. Similarly, insurers either do not sell, or charge substantially higher rates, to older elderly, who are most likely to need long-term care.

Second, the policies initially on the market (which still constitute the bulk of policies in effect) included a number of benefit restrictions. Among them were exclusions for specific conditions (such as Alzheimer's disease), requirements for hospital stays or skilled care before coverage of long-term personal care, and limited coverage of home care (where increases in use stimulated by coverage are of greatest concern). Furthermore, benefits in these early policies were specified in fixed dollar terms (for instance, $50 per nursing home day). As a result, a benefit that appeared adequate at the point of purchase might prove to be woefully limited when the purchaser needed services 20 to 40 years later.

Policies have recently been developed that offer broader coverage. New policies specifically cover Alzheimer's disease; benefits are less likely to be contingent on prior use of hospitals or skilled nursing homes; and many of these newer policies include partial protection against inflation. However, most people who have purchased coverage do not hold these newer policies, and to change policies means losing the accumulated value in a policy that is dropped.[59]

During the past two years long-term care insurance policies also have expanded their coverage and scope of benefits for home care. Of the 28 policies offered for the first time by members of the Health Insurance Association of America (HIAA) in 1988 and 1989, most paid beneficiaries of home care at 50 percent of the purchased daily nursing home benefit. Thirteen of the plans, however, required a prior nursing home stay to obtain home care benefits, and five of those also required a prior hospital stay.[60]

Alongside insurers' own efforts to improve policies have come efforts by state regulators to protect consumers. Concern over consumer protection, reinforced by the sales abuse experience and overpriced (relative to their value) Medigap and life insurance policies, led the National Association of Insurance Commissioners (NAIC) to develop a regulatory framework for long-term care insurance. Over the past several years, as the market has developed and products have changed, so too have the model regulations. The NAIC first issued model regulations for states to adopt in 1986. These were substantially broadened in 1987, 1988, and 1989.[61] Two-thirds of the states have adopted *some* version of the NAIC regulations or even more stringent regulations, but most of the states have not kept up with all the changes.[62] And while the NAIC continues to respond to the changing market, it has not yet addressed all the issues confronting consumers.

The long-term care market continues to pose considerable risk despite insurer and regulator efforts.

First, inflation protection remains limited, potentially exposing people with coverage to substantial costs should they need care.

Second, many policies still limit their period of coverage. A 1988 analysis of 29 policies conducted by the HIAA found that 28 limited the length of the coverage period, typically to a maximum of four or five years.[63] Since it is estimated that among people who use nursing home care, almost one in five will exceed five years of care over their lifetimes, these maximum lifetime benefit provisions would severely limit protection.[64]

Third, even though regulation may prohibit insurers from raising premiums or canceling policies for specific individuals, insurers are allowed (and may find it necessary) to raise premiums for groups—or cancel whole sets of policies—if financial experience warrants. People who have paid premiums for years can be without protection.

Finally, long-term care insurance is relatively expensive, and the better the protection it offers the more it is likely to cost. The Health Insurance Association of America reports that today, a typical good policy—one that covers home care and four years of nursing home care at $80 a day, and offers some inflation protection—costs, on average, $658 if purchased at age 50; $1,395 at age 65; and $4,199 at age 79.[65]

Some argue that as elderly people become more aware of the risk they face in long-term care and as better products become more widely available, many elderly—perhaps as many as half—will buy coverage.[66] The fact is, however, that only an estimated 3 percent to 5 percent of the elderly population currently own long-term care insurance policies.[67] And for many elderly the financial burden of these policies is patently prohibitive. At least 40 percent of elderly people have incomes below twice the poverty level (about $12,000) in 1990. For them, premiums for the typical policy described above would clearly impose an enormous burden. Even for a moderate income 65-year-old (with income between 200 percent and 300 percent of the federal poverty level—$12,000 to $18,000) premiums would absorb between 8 percent and 12 percent of income. Only about 6 percent of today's elderly could purchase such a policy using as little as 5 percent of income.[68]

Alternatives to free-standing long-term care insurance, such as Social/Health Maintenance Organizations (S/HMOs) and Continuing Care Retirement Communities (CCRCs) or life-care communities, are also available to help finance long-term care. S/HMOs, publicly sponsored demonstrations in four cities, are designed to integrate the concept of insurance with the delivery of long-term care in a manner analogous to health maintenance organizations, on a capitated, per person basis. A recent evaluation of this project indicates that only two S/HMOs have achieved their 4,000 member target enrollments.[69] CCRCs were originally developed to integrate insurance and service delivery with housing. About one-third of the more than 700 CCRC s in the United States offer insurance protection through risk sharing arrangements among residents.[70]

Both mechanisms aim to control costs through efficient service delivery, making benefit restrictions unnecessary and protection more affordable. However, neither offers a clear-cut strategy for providing good coverage at broadly affordable costs.[71] S/HMOs have limited the long-term care services they offer in order to keep their rates affordable. Life care communities exclude people with health problems, usually charge substantial entry fees, and, increasingly, do not include long-term care insurance in the cost of joining the community. Either a separate policy is sold, or residents of the community pay, on a fee-for-service basis, for the services they need.

Finally, new mechanisms are becoming available to free up elderly people's resources to finance long-term care. Home equity conversions would allow elderly people to convert what is frequently their largest asset—their house—into income. Banks would provide individuals annuities or lines of credit, to be repaid from the sale of the house at the individual's death. Riders on life insurance policies have also become available that would allow individuals to convert their death benefits to long-term care benefits under certain circumstances.

Each has some potential to provide elderly people access to their savings or assets, although the process of trading assets for income is not without complications and raises a number of issues of consumer protection.[72] But access to savings is *not* the same as insurance. Insurance is designed to protect income and assets, not convert them. Insurance is also intended to cover the costs of service needs. Cash income derived from either housing or life insurance may bear little relation to these needs.

Recognizing the limits to the individual insurance market aimed at the elderly, some insurers have recently turned to employers as a better way to spread the risk and to market their products. Job-based policies have the potential to spread the financial risk among low-risk as well as high-risk purchasers, and allow the financing of insurance over the working years of the employee. Further, they have lower marketing and administrative costs. Premiums for individual policies tend to be 20 percent to 30 percent higher or more for the same coverage sold through an employer-sponsored plan.[73]

While such plans were unheard of three years ago, the number of employers offering this coverage has grown from a mere two in 1987 to 47 in 1989, with another 64 to become effective in 1990. In addition to employees, most of the plans were offered also to retirees and their spouses, current employees' spouses, and the parents and parents-in-law of the employees. Of the 51,368 persons enrolled in employer-sponsored long-term care plans as of the end of 1989, half were active employees. The rest were retirees and their spouses or immediate relatives of the employee.[74]

The development of job-based coverage is encouraging, but except for a few pilot programs negotiated by the United Auto Workers with Ford and Chrysler, the premiums for the insurance are still paid entirely by employees. Furthermore, even in the larger firms offering coverage, availability of coverage depends on each individual's health status.

Enthusiasm over the prospects of restructuring employee compensation to include long-term care insurance must be tempered by the realization that employers are preoccupied with controlling their health care costs and accounting for postretirement medical benefits. Fear of creating an unintended liability—analogous to employers' experience with postretirement medical benefits—may inhibit employers from expanding benefits to include long-term care. In addition, too few employees are affected by long-term care needs at any one time to constitute a critical mass agitating employers to change their employee compensation to add this benefit. It must be remembered that even for more common employee benefits, such as health plans and pensions, coverage is not universal. In 1986, over 40 percent of employers did not provide health insurance to their employees.[75] In 1986, less than half of all full-time employees were covered by pension plans.[76]

Most important, even if employers offer and employees purchase benefits, job-based coverage—like individual coverage—does not guarantee adequate protection. Unlike health coverage, where people pay in every year to cover costs *in that year,* for the most part long-term care coverage means paying in over a number of years for coverage most likely to be used after retirement. Therefore, ensuring the adequacy of long-term care benefits, like ensuring the adequacy of pensions, means addressing such issues as portability of coverage across employers (including movement from an employer who offers insurance to an employer who does not) and some return on employees' contributions even if participation should lapse.

In sum, for today's disabled population, private long-term care insurance is not an option. Insurers do not sell policies to persons who are already impaired. The current market is relatively small—at the most 5 percent of the elderly population held policies in 1989. Furthermore, premiums would absorb an enormous share of income for most elderly, and policies would typically still leave many costs uncovered. The greatest potential for private insurance to play a major role in the financing of long-term care thus lies in the future.

Future Prospects for the Market

The emergence of job-based coverage, combined with expected improvements in the average income of the elderly population, makes some observers optimistic that private insurance coverage will grow until it fills a considerable part of the need for long-term care protection.

The extent of long-term care insurance in the future depends on people's behavior: how many people will purchase long-term care insurance during their working years, how many will continue paying premiums for the rest of their lives, and how many people who do not buy such insurance before retirement will be willing and able to purchase it after they retire.

Most policies are marketed as lifetime decisions. That is, the price does not reflect the current risk of needing long-term care but, rather, is based on an average lifetime risk. Consequently, the price of a policy purchased by a nonelderly person is low relative to the risk later in life, but high relative to the risk of needing long-term care in the earlier years. Some insurers are considering policies that refund part of the premium paid but, in current policies, once payments cease the policy no longer has any value. With no refunds and without any inflation protection, insurance purchased at age 30 costs a tenth of what the same policy costs at age 65.[77]

Will a 50-year-old, who might not need any long-term care for 25 or more years, be willing to buy a policy that will pay $50 a day for a nursing home stay and $25 a day for home health care? The answer depends on the potential purchaser's assessment of several risks, including the risk that his or her expectations about inflation and the future cost of long-term care will be wrong, that he or she will not be able to afford to continue to pay the premium, or that the insurer will not honor the policy (either because the company is no longer in business or because that type of policy was cancelled). It also depends on the extent to which employers are willing to subsidize premiums of workers and, if so, how government regulates the insurance market. Both are uncertain.

Will a retiree continue to pay premiums after retirement or buy coverage for the first time? The future behavior of the elderly will depend heavily on their incomes and assets. Successive groups of elderly people will stop working with more retirement income and income from savings. Therefore, the average income of the elderly, adjusted for inflation, is projected to increase.[78]

Despite improvements over time, however, there will still be elderly for whom long-term care insurance is simply too expensive. Among *workers* expected to retire between the year 2012 and 2021, for example, about 18 percent will have retirement incomes (pensions, retirement accounts, social security) below 125 percent of poverty.[79]

About 80 percent of unmarried elderly women and 60 percent of unmarried elderly men will have incomes from all sources of less than $20,000 (1988 dollars) in 2030—leaving premiums for long-term care insurance in excess of 5 percent of income for more than 70 percent of the unmarried elderly in 2030 (if they do not purchase insurance until after age 64). For 48 percent of all elderly (married or not), a premium of $720 a year is projected to be within 5 percent of their gross income in 2030. For another 23 percent, such a premium would be within 10 percent of their income.[80] In today's market, however, a $720 policy would provide only limited coverage.

The uncertainty of income, assets, consumer preferences, and the quality of the products offered makes it difficult to estimate the scope of long-term care coverage in the future with any precision. Estimates prepared for the Commission indicate that by the year 2018 from 24 percent to 48 percent of the elderly might actually have coverage, assuming a less comprehensive policy (less home care, lower payments per day of nursing home care) than the typical "good" policy reported by the HIAA.[81] Estimates depend heavily on how many employers are projected to provide access to long-term care insurance policies.[82] The top of the range—48 percent—is the proportion of elderly for whom premiums would be within 5 percent of income.

> ***"During the early 1960s it was considered intolerable that only half of the elderly had some form of acute care insurance. Based on our work, private long-term care insurance will be lucky to reach that level of market penetration."***
>
> ***—Joshua M. Wiener, senior fellow, The Brookings Institution***

The development of private insurance for long-term care may alleviate financing problems for some portion of the future elderly and nonelderly disabled population. But the adequacy and scope of that protection cannot be ensured without government oversight and support. Furthermore, even if private insurance protection grows substantially, two critical questions will remain:

- How to protect the currently disabled population as private insurance expands,
- How to protect the population that will inevitably be left out.

PROSPECTS FOR THE FUTURE

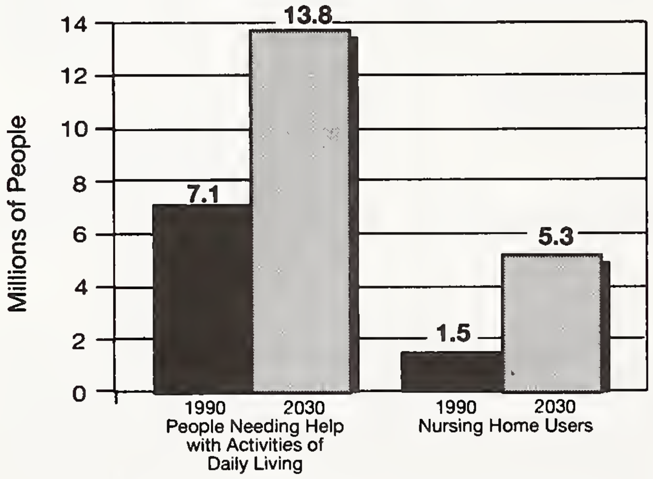
Growth in the numbers of people likely to need long-term care makes improvements in the nation's financing of this care not only important but imperative to the well-being of all Americans. The size of the population over age 65—and, more important, over age 85—is increasing. As a result, the demand for long-term care will almost certainly rise substantially. Even among the younger population, needs can be expected to grow. Experience so far raises serious doubts about the adequacy of current long-term care mechanisms to respond to greater need.

Changing Needs

Growth in the numbers of older people reflects several demographic trends, including longer lifespans for older people and the aging of the baby boom generation. Thirty-two million Americans are now age 65 and over. That number is expected to double between now and 2030, even on the conservative assumption that improvements in longevity slow to half their historical rate. In roughly the same period, the population age 85 and older is expected to increase almost fivefold (from 2.5 million to as many as 12 million).[83]

More older people, especially more very old people, is likely to mean greater need for long-term care. Exactly how much greater is uncertain. Medical advances could reduce people's need for care, but longer lifespans could also increase this need. If disability rates remain what they are today, by 2030 the number of elderly persons needing help with basic tasks is expected to increase from about 7 million to 13.8 million and the number requiring nursing home care, from 1.5 million to 5.3 million (see Figure 3-9).[84]

Figure 3-9 Number of Elderly Needing Long-Term Care, 1990 and 2030*



*Projected

SOURCE: For 1990, Lewin/ICF estimates using the Brookings/ICF Long-Term Care Financing Model; for 2030, Shelia Zedlewski, et al., *The Needs of the Elderly in the 21st Century* (Washington, D.C.: The Urban Institute, 1990).

Growth in the elderly population is the major but not the only source of potentially increased long-term care needs. The use of high technology and new medical breakthroughs may continue to extend the lives of more mentally retarded, developmentally disabled, and physically disabled persons. Increased survivorship of low birthweight children, greater longevity for children with terminal chronic illness, and earlier detection of chronic health problems have doubled the proportion of disabled children under 17 over the last 25 years—from less than 2 percent in 1960 to more than 5 percent in 1984.[85] This growth will undoubtedly continue in the future.

In addition, we are just beginning to recognize the long-term care consequences of the AIDS epidemic. A recent study in five communities points to much unmet need for long-term care already among AIDS patients in both institutions and the community.[86] The demand for care will undoubtedly grow as more persons are diagnosed with HIV-positive infections.

Capacity to Respond

The capacity of families and programs to provide needed care is already severely strained. It seems highly unlikely that service availability will keep up with the growing service needs.

First, availability of family care, on which people depend if they are to remain at home, is likely to diminish.[87] Specifically, the recent decline in fertility rates suggests that there will be fewer adult children potentially available to provide care. The continued increase in female labor force participation, coupled with the trend toward delayed childbearing, also can be expected to lead to fewer adult children potentially available to provide care. Daughters, in particular, will be less able and willing than the current generation of adult children to care for their elderly parents because of the competing demands of employment and child care. Larger numbers of younger elderly, between 65 and 70, may offset the loss of caregivers due to employment. But the prospects are uncertain.

EARL DOTTER

As the roles of women change, daughters will be less able to care for elderly parents.

Second, future elderly will be financially better-off, facilitating their ability to purchase care. But projected income improvements are heavily concentrated among the younger elderly, rather than the older population most likely to need care. Between 1990 and 2020, real incomes of people 65 to 74 are expected to double. Among the population 85 and older, however, real incomes are expected to increase only 17 percent.[88] The capacity of people who most need the care to pay for it will remain decidedly limited.

> ***"[T]he increasing population frailty and the increasing need for women to be in the labor force . . . is a very fragile basis for the nation's long-term care policy. . . . Of these caregivers, over 50 percent are working, and a large proportion of them already make work sacrifices themselves, limiting their own future coverage and social security and benefits, and are contributing substantially in a number of cases from their own financial income to try to support their elderly relatives."***
>
> *—Dr. Carroll Estes, director,*
> *Institute of Health and Aging,*
> *University of California, San Francisco*

Whether services will be available if people are able to pay is also an open question. Use of paid care in the home is very limited today, even among people with higher incomes. Among the likely reasons for limited use is the difficulty individual consumers face in identifying reliable providers of long-term care services. Traditional health care providers are often reluctant to provide and organize the array of services that disabled people require. Suppliers of homemaking, transportation or other services that are part of long-term care can be reluctant to serve a disabled population. Without government involvement, the private marketplace seems unable to develop a delivery system to deliver needed services efficiently to the disabled population.

As currently structured, existing programs are unlikely to provide the requisite public leadership. Medicare's focus on people who need skilled care, even with more liberal definitions, precludes extended long-term care assistance. In theory, Medicaid benefits might allow broader service, at least for people poor enough to qualify. In practice, however, federal rules and expenditure concerns in most states are likely to continue to limit service. Without more federal assistance, even states now building long-term care programs with heavy reliance on their own funds are likely to be unable to keep up with the need for care.

Although most states have little investment in home care, almost all are heavily involved in nursing home support. But that involvement by no means guarantees sufficient support to meet growing needs. Research indicates that unless low-income people buy private coverage, even substantial expansion of private insurance will have only modest effects on the future need for publicly financed nursing home care.[89] Insurance will be expensive; the better its protection, the more it will cost. Low-income people will almost certainly find themselves without private coverage. Job-based long-term care coverage is unlikely to reach large numbers of middle-income workers in their retirement years. Many of these people, like the current elderly, will have to depend on public programs for nursing home care.

It is unlikely that a welfare-based program will attract the substantial resources necessary to meet these needs. If Medicaid were to provide coverage 30 years from now on the same terms it does today, its expenditures—measured net of general inflation—would be almost triple what they are now, even if private insurance were to expand dramatically.[90] These estimates assume that nursing home costs will increase faster than inflation. Even if costs are held to general inflation rates, greater use alone would increase real Medicaid spending by about 75 percent.

> ***"What we have now is a perverse [Medicaid] system. It needs to be changed from a non-system that kicks people when they're down to an insurance program that helps people plan for their later years for themselves and for their loved ones."***
>
> ***—Senator Max Baucus***

Experience over the last decade suggests that Medicaid will not achieve the coverage or spending levels necessary to support nursing home use at current levels. Nursing home use has *not* kept pace with growth in the elderly population and the estimated need for long-term care, and in many places the need for nursing home care exceeds the supply of beds. Under these circumstances today's Medicaid patients have trouble finding nursing home care. Without a change in public policy, more and more Americans will have difficulty getting the care they need, in nursing homes as well as at home.

Notes to Chapter 3

1. R.L. Associates, *The American Public Views Long-Term Care* (Washington, D.C.: American Association of Retired Persons and the Villers Foundation, 1987).

2. Sidney Katz et al., "Studies of Illness in the Aged," *Journal of the American Medical Association* 31 (September 1963): 914.

3. M. Powell Lawton and Elaine M. Brody, "Assessment of Older People: Self-Maintaining and Instrumental Activities of Daily Living," *The Gerontologist* 9 (1969): 179.

4. Joshua M. Wiener and Raymond J. Hanley, *Measuring the Activities of Daily Living Among the Elderly: A Guide to National Surveys,* Final report, prepared for the Interagency Forum on Aging-Related Statistics (Washington, D.C., October 1989).

5. Mitchell P. LaPlante, "Disability in Basic Life Activities Across the Lifespan," *Disability Statistics Report* 1 (January 1989); and William J. Scanlon, "A Perspective on Long-Term Care for the Elderly," *Health Care Financing Review* (1988 Annual Supplement): 7.

6. Estimates of the size of the disabled elderly population referred to in the rest of this chapter, unless otherwise noted, are those prepared by David Kennell and Lisa Alecxih using the Brookings/ICF Long-Term Care Financing Model.

7. Estimates of the size of the disabled nonelderly population referred to in the rest of this chapter, unless otherwise noted, are derived from unpublished data from the *1987 National Medical Expenditures Survey.*

8. Paul W. Newachek, "The Costs of Caring for Chronically Ill Children," *Business and Health* 4 (January 1987): 18. [Hereinafter cited as Newachek, "Costs of Caring."]

9. U.S. Congress, Office of Technology Assessment, *Technology-Dependent Children: Hospital v. Home Care: A Technical Memorandum* (Washington, D.C., Government Printing Office, 1987): 3.

10. Esther Hing, Edward Sekscenski and Genevieve Straha, *The National Nursing Home Survey: 1985 Summary for the United States,* Vital and Health Statistics. Series 13, No. 97, DHHS Pub. No. (PHS) 89–1758 (Washington, D.C.: Government Printing Office, 1989).

11. Joshua M. Wiener and Kathryn M. Harris, "Myths and Realities: Why Most of What Everybody Knows About Long-Term Care is Wrong," *The Brookings Review* (Washington, D.C.: The Brookings Institution, in press). [Hereinafter cited as Wiener and Harris, "Myths and Realities."]

12. Brookings/ICF Long-Term Care Financing Model.

13. Ibid.

14. Wiener and Harris, "Myths and Realities."

15. Denise Spence and Josha M. Wiener, "Nursing Home Length of Stay Patterns: Results from the 1985 National Nursing Home Survey,"? *The Gerontologist* 30 (1) (1990): 18.

16. Korbin Liu, Kenneth G. Manton, and Barbara Marzetta Liu, "Home Care Expenses for the Disabled Elderly," *Health Care Financing Review* (Winter 1985): 51. [Hereinafter cited as Liu, Manton, and Liu, "Home Care Expenses."]

17. Robyn I. Stone and Peter Kemper, "Spouses and Children of Disabled Elders: How Large a Constituency for Long-Term Care Reform?" *The Milbank Quarterly* 67 (3–4) (1989): 485. [Hereinafter cited as Stone and Kemper, "Spouses and Children."]

18. The following discussion of informal caregivers of disabled elders draws heavily on Robyn I. Stone, Gail Lee Cafferata, and Judith Sangl, "Caregivers of the Frail Elderly: A National Profile," *The Gerontologist* 27 (1987): 616.

19. Liu, Manton, and Liu, "Home Care Expenses," 51.

20. General Accounting Office, *Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs* (Washington, D.C.,

GAO/HRD–87–9, December 1986), 21; Judith Feder, "Financing Home Care for the Elderly: Roles and Limits of Public Programs," paper prepared for the Commonwealth Fund Commission on Elderly People Living Alone (Washington, D.C., March 1989). [Hereinafter cited as Feder, "Financing Home Care."]

21. Debra Lipson and Elizabeth Donohoe, *State Financing of Long-Term Care Services for the Elderly* (Washington, D.C.: Intergovernmental Health Policy Project, 1988). [Hereinafter cited as Lipson and Donohoe, "State Financing of Long-Term Care."]

22. Feder, "Financing Home Care," 38.

23. This discussion of funding for home and community based care relies heavily on Feder, "Financing Home Care," 30.

24. Feder, "Financing Home Care," 30.

25. U.S. Congress, House Committee on Energy and Commerce, Subcommittee on Health and the Environment, *Medicaid Source Book: Background Data and Analysis,* report prepared by the Congressional Research Service, 100th Cong., 2d Sess., 1988, Committee Print 100–AA, 155–161. [Hereinafter cited as *Medicaid Source Book.*]

26. Peter Kemper, Robert Applebaum and Margaret Harrigan, "Community Care Demonstrations: What Have We Learned?" *Health Care Financing Review* 8 (4) (1987): 87; William Wiessert, C. Cready, and J. Pawelak, "The Past and Future of Home and Community-Based Long-Term Care," *The Milbank Quarterly* 66 (2) (1988): 309.

27. *Medicaid Source Book,* 158.

28. Ibid., 163.

29. Ibid., 159.

30. Paul W. Newachek, Harrietta B. Fox, and Margaret A. McManus, "Home Care Needs of Chronically Ill Children," *Caring* (June 1988): 4.

31. Carol O'Shaughnessy and Richard Price, *Financing and Delivery of Long Term Care Services for the Elderly* (Washington, D.C.: Congressional Research Service, Report 88–379, March 2, 1988).

32. Carol O'Shaughnessy, *Older Americans Act Programs: Brief Summary, Funding Levels and FY 1991 Budget Request* (Washington, D.C.: Congressional Research Service, Report 90–200, March 30, 1990).

33. Lipson and Donohoe, "State Financing of Long-Term Care."

34. Diane Justice, "State Community-Based Care Systems," *Generations* 24 (2) (Spring 1990): 45.

35. Jon B. Christianson, "The Evaluation of the National Long-Term Care Demonstration: The Effect of Channeling of Informal Caregiving," *Health Services Research* 23 (1) (April 1988): 99.

36. Perry Edelman and Susan Hughes, "The Impact of Community Care on Provision of Informal Care to Homebound Elderly Persons" *The Journals of Gerontology* 45 (2) (March 1990): 574.

37. Brookings/ICF Long-Term Care Financing Model.

38. Thomas Rice, "The Use, Cost, and Economic Burden of Nursing-Home Care in 1985," *Medical Care* 27 (12) (December 1989): 1133.

39. U.S. Congress, House Committee on Ways and Means, *Overview of Entitlement Programs: 1990 Green Book,* 101st Cong., 2d Sess., 1990, WMCP 100–293.

40. Korbin Liu, "Recent Changes in the Medicare Skilled Nursing Facility Benefit," *Generations* 14 (Spring 1990): 75.

41. Brookings/ICF Long-Term Care Financing Model.

42. These estimates are derived from the Brookings/ICF Long-Term Care Financing Model. They take into account 1988 guidelines for determining "skilled" care, which increased the average length of stay covered by Medicare from 30 days to an estimated 45 days and increased expenditures by about 40 percent. See Liu, "Recent Changes," 75.

43. Unpublished data from the Health Care Financing Administration, Office of the Actuary, Data from the Office of National Cost Estimates, 1988.

44. This discussion of the Medicaid eligibility process draws on *Medicaid Source Book,* 356–366.

45. Eligibility can be denied for a period of time to people who have transferred their assets for less than fair market value within the 30-month period prior to application for benefits.

46. Unpublished data from the *1987 National Medical Expenditures Survey.*

47. Denise Spence and Joshua M. Wiener, "Estimating the Extent of Medicaid Spend-down in Nursing Homes," *Journal of Health, Politics, Policy and Law* (in press). These estimates are based on nursing home discharges.

48. Ibid.

49. Institute of Medicine, *Improving the Quality of Care in Nursing Homes* (Washington, D.C.: National Academy Press, 1986).

50. John Holahan and Joel Cohen, "Nursing Home Reimbursement: Implications for Cost Containment, Access and Quality," *The Milbank Quarterly* 65 (1) (1987): 112.

51. *Medicaid Source Book,* 472–483; Brookings/ICF Long-Term Care Financing Model.

52. William J. Scanlon, "A Theory of the Nursing Home Market," *Inquiry* 17 (Spring 1980): 25; *Medicaid Source Book:* 472–482.

53. *Medicaid Source Book,* 473.

54. Robert B. Friedland, "Issues Concerning the Financing and Delivery of Long-Term Care," *EBRI Issue Brief* 86 (January 1989): 16.

55. Health Insurance Association of America, "Highlights from the 1989 Long-Term Care Survey," unpublished data presented at the annual Private Long-Term Care Insurance Conference, Orlando, Fla., March 1990. [Hereinafter cited as Health Insurance Association of America, "Highlights."]

56. Ibid.

57. For discussions of private long-term care insurance, see Robert Friedland, *Facing the Costs of Long-Term Care* (Washington, D.C.: Employee Benefit Research Institute, 1990) [Hereinafter cited as Friedland, "Facing the Costs of Long-Term Care."]; Alice Rivlin and Joshua M. Wiener, *Caring for the Disabled Elderly: Who Will Pay?* (Washington, D.C.: The Brookings Institution, 1988), Chapter 4 [Hereinafter cited as Rivlin and Wiener, *Caring for the Disabled Elderly*]; William Scanlon, "A Perspective on Long-Term Care for the Elderly," *Health Care Financing Review* (1988 Annual Supplement): 7–15; Stanley Wallack, "Recent Trends in Financing Long-Term Care," *Health Care Financing Review* (1988 Annual Supplement): 97–102; U.S. Department of Health and Human Services, *Report to the Secretary on Private Financing of Long-Term Care for the Elderly,* report prepared by the Technical Work Group on Private Financing of Long-Term Care for the Elderly (Washington, D.C., November 1986). [Hereinafter cited as U.S. DHHS, *Report to the Secretary.*]

58. Rivlin and Wiener, *Caring for the Disabled Elderly:* Chapter 4; Friedland, *Facing the Costs of Long-Term Care,* Chapter 6.

59. These policies are sold, like universal or whole life insurance, on an entry age basis. That is, the price for the life of the policy is based on the age at purchase. If purchased at age 50, for example, the price remains at the age 50 level. Premiums will only increase if the price for all those 50 years of age is increased. However, if after 10 years the policy is dropped and a new policy is purchased, the price is based on the applicant's advanced age of 60. The premiums paid over the 10 years included the risk of needing long-term care during those 10 years, plus a portion saved to keep the premiums the same over the life of the policy holder. This "prefunding" of future insurance premiums is therefore lost when the policy is dropped.

60. Health Insurance Association of America, "Highlights."

61. National Association of Insurance Commissioners, NAIC Long-Term Care Model Act and Regulation (Kansas City, Mo.: NAIC, 1986, 1987, 1988, 1989).

62. Friedland, *Facing the Costs,* 217.

63. Susan Van Gelder and Diane Johnson, "Long-Term Care Insurance: Market Trends," *Research Bulletin* (Health Insurance Association of America, March 1989).

64. Peter Kemper and Christopher M. Murtaugh, "Long-Term Care Financing Reform: Implications of New Evidence on Lifetime Nursing Home Use," abstract prepared for the seventh annual meeting of the Association of Health Services Research of the Foundation for Health Services Research (Arlington, Va., June, 1990), 54.

65. These estimates represent the average costs of a premium for a policy sold by the 15 leading companies marketing private long-term care insurance. These estimates were ascertained through personal communication with Diane Johnson of the Health Insurance Association of America.

66. Pepper Commission, *Assessing the Affordability of Private Long-Term Care Insurance,* testimony of Stanley S. Wallack, 101st Cong, 1st Sess., 1989, S. Hrg. 101-656, 56.

67. Wiener and Harris, *Myths and Realities;* and Health Insurance Association of America, "Highlights."

68. Brookings/ICF Long-Term Care Financing Model.

69. Charlene Harrington and Robert J. Newcomer, "Social Health Maintenance Organizations," *Generations* 14 (Spring 1990): 49.

70. American Association of Homes for the Aging, *Continuing Care Retirement Communities: An Industry in Action. Analysis and Developing Trends* (Washington, D.C.: AAHA, 1987).

71. Rivlin and Wiener, *Caring for the Disabled Elderly;* Friedland, *Facing the Costs.*

72. Ibid.

73. Friedland, *Facing the Costs,* 220.

74. Health Insurance Association of America, *Highlights.*

75. See Chapter 1, Figure 1-6.

76. Joseph S. Piacentini and Timothy J. Cerino, *FBRI Databook on Employee Benefits* (Washington, D.C.: Employee Benefit Research Institute, forthcoming).

77. U.S. DHHS, *Report to the Secretary,* Appendix.

78. Rivlin and Wiener, *Caring for the Disabled Elderly,* 38; Sheila R. Zedlewski et al., *The Needs of the Elderly in the 21st Century* (Washington, D.C.: Urban Institute, 1990). [Hereinafter cited as Zedlewski et al., *The Needs of the Elderly.*]

79. Deborah J. Chollet, "Financing Retirement Today and Tomorrow: The Prospect for America's Workers" in *America in Transition: Benefits for the Future* (Washington, D.C.: Employee Benefit Research Institute, 1987).

80. Zedlewski et al., *The Needs of the Elderly,* Table 4.1.

81. The policy modeled for this analysis covers 4 years of nursing home care at $50 per day (after a 100 day deductible) and offers limited inflation protection and limited home care. Those with access to an employer plan will be able to purchase coverage for as little as $189 a year if they initially purchase before age 55. At age 65 the policy would cost $466 and at age 75 the price is $1,004. For those without access to an employer-sponsored plan the annual premiums at these three age groups are $236 before age 55, $583 at age 65, and $1,255 at age 75.

82. The Brookings/ICF Long-Term Care Financing Model assumed that the decision to purchase long-term care insurance depended on age; income; whether or not one had access to an employer sponsored long-term care insurance policy; and in the case of the elderly, assets. Among those with access to an employer sponsored policy, the likelihood of a purchase was not considered unless premiums were 2 percent or less of an individual's income, if they were under the age of 50; 3 percent or less of an individual's income, if they were age 50 to 59; and 4 percent or less of income, if they were age 60 to 64. The probability of a purchase ranged from 5 percent to 25 percent, depending on age and the relative size of the premium. For those under the age of 50, the probability of a purchase was assumed to increase from 5 percent to 10 percent if premiums were less than 1.5 percent of the individual's income. For premiums less than 1 percent, the probability was assumed to increase to 15 percent. For those age 50 to 59, the probability of purchasing long-term care insurance was 20 percent when premiums were less than 1 percent of an individual's income and for those age 60-64, the probability was assumed to increase to 25 percent.

For the elderly, the Brooking/ICF Long-Term Care Financing Model assumed that individual long-term care insurance would not be considered if premiums were in excess of 5 percent of individual income for those individuals whose family did not have more than $10,000 in assets. All other elderly were likely to buy based on the following probabilities, based on the individual's income: 2 percent, if premiums were between 4 and 5 percent of an individual's income; 3 percent, if premiums were between 3 and 4 percent of their income; 4 percent, if premiums were between 2 and 3 percent of their income; 5 percent if premiums were less than 2 percent of their income.

Employer involvement in making long-term care insurance available to employees is assumed to grow during the simulation period. The simulation assumes that employers will gradually sponsor plans for employees and their dependents to participate. Specifically, each year an additional 2.5 percent of employers who offer pension plans will offer long-term care insurance to their employees and dependents, so that by 2008, half of all employers providing pensions will offer access to long-term care insurance. In addition, 20 percent of the employer-sponsored plans were assumed to subsidize half of the long-term care insurance premium. The variation in the proportion of elderly with long-term care insurance policies is heavily affected by employer participation rates that are greater or less than this assumed rate of growth.

Since the Brookings/ICF Long-Term Care Financing Model is a microsimulation model, the decision to purchase is made each year of the simulation. That is, assuming an individual did not purchase the policy in the first simulated year did not preclude them from making the purchase in a subsequent simulation year. Therefore, the probability of purchasing a policy over the lifetime of the simulation depends on the initial age of the individual and the number of years simulated. Once the decision to purchase was made, it was assumed that the individual held onto that policy for the remainder of the simulation, unless their income should drop considerably so that premiums now exceeded a new threshold as a percent of their income. These new thresholds increased with the age of the policy holder. For those under the age of 50, policies were dropped if the premiums were to exceed 4 percent of their income; for those age 50 to 59, policies were dropped if premiums were to rise to 5 percent of their income; 6 percent was assumed to be the threshold for those age 60 to 64; 7 percent for those age 65 to 69; and 8 percent of those age 70 or older.

83. Zedlewski et al., *The Needs of the Elderly.*

84. Brookings/ICF Long-Term Care Financing Model for Current Estimates; Ibid. for 2030.

85. Newacheck, "Costs of Caring," 18.

86. General Accounting Office, *AIDS: Delivery and Financing Health Services in Five Communities* (Washington, D.C.: GAO/HRD 89-120, September 1989).

87. Stone and Kemper, "Spouses and Children," 485.

88. Rivlin and Wiener, *Caring for the Disabled Elderly,* 11-12.

89. Private insurance is estimated to reduce Medicaid spending by one to five percent below levels that would be reached in its absence, assuming people spend no more than five percent of their income in purchasing care. More generous assumptions about purchasing behavior have a bigger impact on public costs. For example, if all people who buy Medigap policies, many of whom have low incomes, were to buy long-term care policies, public costs would be 15 percent lower than otherwise. See Rivlin and Wiener, *Caring for the Disabled Elderly,* Chapter 4.

90. Rivlin and Wiener, *Caring for the Disabled Elderly,* Chapter 2.

Chapter 4

Blueprint for Long-Term Care Coverage for All Americans

Chapter 4

Blueprint for Long-Term Care Coverage for All Americans

The Commission believes that federal action is essential to change the nation's fundamentally flawed approach to financing long-term care, and that such action should follow an insurance strategy.

The Commission rejects the other principal strategy, that of encouraging private savings to cover the cost of long-term care. While the encouragement of savings is, independently, a policy goal that might well deserve support, it is inappropriate in this context. It concentrates the financial burden of severe impairment, an expensive and largely unpredictable event, on the unlucky few who experience it, rather than spreading it among the many who are at risk of impairment.

In the absence of insurance protection, becoming disabled means inadequate support for millions of Americans who struggle to remain at home and the risk of impoverishment if and when people need nursing home care. Failure to reform the system is not only to abandon today's elderly and disabled but also to condemn growing numbers of Americans to inadequate access to care in the future.

To prevent this outcome, the Commission unanimously adopted the following goal:

> The Commission is committed to the development of public policies that give Americans of all ages access to coverage that provides them necessary long-term care and adequate financial protection.
>
> Regardless of the strategy chosen, coverage should:
>
> - Treat long-term care as an insurable event—that is, an event whose risk can be spread through private and/or public coverage;
> - Be affordable to all Americans;
> - Allow personal choice of care and setting; and
> - Assure quality care and provide for consumer protection.
>
> The Commission is equally committed to agreement on how to raise the financing required to assure access, through public and/or private means; to developing policies that control costs of current and future long-term care services; and to promoting research on preventing or reducing disabilities that create a need for long-term care.

The Commission explored a range of possible strategies to achieve this objective (see Appendix B for a detailed discussion). One strategy is to enhance government protection for the low-income population and promote adequate private insurance protection for the better off. The Commission concludes, however, that to build such a two-tiered system would be to repeat the nation's unfortunate experience in health care. Now and in the future, too many people—most likely people who have worked hard all their lives to earn modest incomes—will find themselves without private protection and dependent on a welfare-based system unable to ensure access to quality care.

Another strategy is to develop a comprehensive public insurance program, for all long-term care services, at home and in nursing homes. The Commission believes that public or social insurance has considerable merit in guaranteeing adequate protection to all Americans regardless of income. However, the Commission is concerned that applying this strategy to all nursing home as well as home care protection requires substantial public resources and provides unlimited protection of assets for people who could protect themselves through private insurance.

In order to target public resources most effectively, guarantee Americans of all incomes adequate protection, and achieve an appropriate balance between public and private insurance, the Commission therefore recommends a limited social insurance approach.

The Commission believes that federal social insurance for home and community-based care is essential to ensure development of an adequate and efficient delivery system for these services and that priority in the use of public resources should go to disabled people at home or able to come home after short nursing home stays. People in nursing homes should be guaranteed an ample floor of protection, ensuring that no one—regardless of length of stay in the nursing home—will become impoverished. And all but the poorest should contribute to the costs of care.

> **"Today . . . we are faced, really, with two choices. We could moan, we can groan about the costs, say it's too difficult a problem to even begin to address. Or we can . . . work toward developing a cost-effective, creative, responsive, and caring program to better address the problems of our chronically ill."**
>
> **—Senator David Pryor**

SUMMARY OF RECOMMENDATIONS

Based on these principles, the Commission recommends developing an integrated public program to meet the diverse needs of severely disabled people and to support private insurance to assist people seeking broader protection. The blueprint has nine parts.

1. *The Commission recommends social insurance for home and community-based care and for the first three months of nursing home care, for all Americans, regardless of income.* Individuals would be required to contribute to the costs of care, with subsidies for people with low incomes. This protection would sustain resources and standards of living when people need long-term care, just as Medicare or private health insurance does when they need physician or hospital services.

2. *For people with long nursing home stays, few of whom return home, the Commission recommends a floor of protection against impoverishment—$30,000 in assets (excluding homes) for individuals and $60,000 for couples—and protection of income for spouses, homes, maintenance, and a decent allowance for personal needs.* Protected assets are approximately equal to the life savings of three out of five elderly people. People whose assets exceed the floor would not receive benefits until their unprotected assets were depleted. Income above protected amounts would be applied toward the cost of nursing home care.

3. Recognizing that many people will want additional protection for assets and income above levels protected for long stays—as well as for cost sharing obligations associated with other benefits—*the Commission recommends measures to promote private long-term care insurance, subject to federal and state oversight.*

Promotion would entail clarification of the tax code to give long-term care insurance the same preferential tax treatment health insurance now receives. Oversight would entail standards for insurance policies, consumer counseling to evaluate policies, and penalties on insurers for failure to comply.

4. The Commission believes that all persons determined to be severely disabled, regardless of age, underlying disease or disabling condition, should be eligible for public benefits, at home or in a nursing home. To qualify for long-term care benefits at home or in a nursing home, *the Commission recommends that individuals meet at least one of the three following disability criteria:* (a) *need hands-on or supervisory assistance with three out of five activities of daily living (ADLs);* (b) *need constant supervision because of cognitive impairment that impedes ability to function;* or (c) *need constant supervision because of behaviors that are dangerous, disruptive, or difficult to manage.* Individuals assessed as severely disabled would be directed to a case manager for assistance in obtaining home care or helped in obtaining a nursing home placement.

5. To ensure that home care services support but do not replace family caregiving and are managed in a fiscally responsible manner, *the Commission recommends relying on case managers to develop and oversee individual care plans.* Within a federally determined budget, case managers would be free to allocate a broad array of services, tailored to people's needs and preferences. *The Commission recommends that benefits include personal care, homemaker/chore services, shopping and other support services, day care (for disabled adults and children), respite services, and training for family caregivers, as well as skilled nursing and rehabilitative care.*

6. Under the recommended plan both federal and state governments would be responsible for financing and administering public benefits. *The Commission recommends that the social insurance portions of the public program be fully financed by the federal government. The federal government and the states would share financial responsibility for long nursing home stays.*

In administering benefits, the Commission seeks a balance between ensuring equal and adequate protection for all severely disabled, regardless of the state in which they live, and allowing flexibility to tailor services to diverse populations and communities. *The Commission therefore recommends that the* *federal government contract with the states to administer the plan. The federal government would be responsible for setting guidelines and adequate standards for this administration.*

The federal government would certify assessment agencies and develop standardized assessment criteria, set guidelines for certifying case managers and establish their budgets (described below), set guidelines for quality assurance and appeals procedures, and determine provider payment rates. Within federal guidelines, states would develop and certify case management and delivery systems, certify providers, establish review and appeals procedures, and enforce quality standards.

7. The Commission recognizes that financial support for long-term care can only be effective if it promotes and ensures quality of care. Furthermore, to be sustainable over the long term, a program must be designed in a way that controls expenditures. The recommended plan therefore includes several measures to ensure quality and control costs. The recently enacted nursing home requirements would apply to the recommended nursing home coverage and standards would be developed for care in the home.

Alongside these standards, the Commission believes that case management, an integral part of its recommended home care benefits, plays a critical role in ensuring quality and managing costs. *The Commission recommends that case managers allocate services and monitor service delivery within a budget set by the federal government.* This approach would ensure fiscal constraint and the capacity to tailor services to the needs and preferences of the individual.

The Commission further recommends that the federal government establish provider payment mechanisms and determine appropriate rates. Prospective payment systems can be used to ensure access to quality care, efficiently delivered, and to control spending for care.

8. The Commission recognizes both the urgent needs of the currently disabled and their families for public support and the time it will take to build a long-term care system. *The Commission therefore recommends that the plan be put into place a step at a time over a four-year period.* The program would begin with limited home care benefits to relieve the burdens of family caregivers. Benefits would be expanded over the next four years, until full coverage is reached. Nursing home coverage would begin in year two. Payment rates would be increased gradually over the subsequent two years, to ensure adequate supply and quality of service.

9. In establishing a system for long-term care, the Commission believes it essential to continue to assess the effectiveness of treatment, delivery, and management of services and to explore means to prevent the need for long-term care services. *The Commission recommends that the federal government move aggressively to contain costs and mitigate human suffering by funding a research and development program aimed at preventing, delaying, and dealing with long-term illness and disabilities.*

THE PUBLIC PROGRAM

The Commission's recommendations create an integrated system of long-term care designed to meet the dynamic needs of the severely disabled population. There would be a single point of entry for all beneficiaries, a single set of eligibility rules for all services, a standardized assessment to determine eligibility, and a mechanism for managing the care process across settings. The system is designed to allow individuals who qualify for service the opportunity to choose the care setting and the types of care they receive, within specified limits. An integrated system would also help ensure efficient administration and service coordination.

Who Is Eligible for Public Benefits

The Commission believes that public benefits are most critical for people who are severely disabled and in need of substantial care. To qualify for any long-term care benefits at home or in a nursing home, *the Commission recommends that individuals meet at least one of the three following disability criteria:* (a) *need hands-on or supervisory assistance with three out of five ADLs;* (b) *need constant supervision because of cognitive impairment that impedes ability to function;* or (c) *need constant supervision because of behaviors that are dangerous, disruptive, or difficult to manage.* Individuals meeting one or more of these criteria, regardless of the underlying disease or disabling condition, would be eligible for benefits.

In proposing these standards, the Commission recognizes the states' success in developing tools to target services to those most in need. In fact, many states already use functional status measures for nursing home screening and for determining eligibility for home and community-based care.[1, 2] Development of these tools is an evolutionary process, however, particularly in the areas of measuring cognitive impairment and children's disabilities. The Commission expects these assessment tools to be refined and become more precise over time.

The Commission favors use of common eligibility standards for in-home and nursing home care. Nevertheless it is concerned that some individuals who would not meet the disability criteria might require nursing home care for other reasons, such as lack of social supports or medical problems not necessarily associated with functional disability. Analysis of data on nursing home residents and states' experience in screening nursing home admissions indicates that the vast majority of current nursing home residents would be eligible for benefits under the public program. To avoid displacing current residents, the Commission recommends that all persons in nursing homes when the program begins be considered to satisfy the program's disability requirements.[3]

The Commission expects that the proposed plan would indirectly benefit those who need long-term care but who are not so severely disabled as to qualify for the new public program. Encouraging the expansion of home care services, coupled with minimum federal standards for managing care and ensuring quality, would make available more and better services for the entire long-term care population, not just for the severely disabled.

How People Become Eligible

Severely disabled individuals face different circumstances. With public support, some will be able to manage at home by themselves or with the help of their families and friends. Others will need nursing home care. To ensure that people obtain services and receive care in settings that are appropriate to their needs, are fully informed about their options, and have an opportunity to choose the kinds of services they prefer, the Commission believes that everyone seeking services should enter the public program through the same process.

The Commission recommends that a federally certified state or local government or nonprofit assessment agency determine people's eligibility for the public program. Assessors would determine whether people satisfy the disability criteria. As appropriate, people would be directed to case management agencies, described below, which would help them identify and obtain the services they need if they prefer to remain at home. The assessment agency would help those who need nursing home care find an appropriate placement.

The Commission chooses not to prescribe the specific auspice or the types of professionals who should conduct assessments. In many communities, social workers or nurses are responsible for client assessments. Other programs use geriatric assessment teams, which frequently include a physician as well as nurses, social workers, and other professionals such as physical therapists. Still others use less credentialed persons who have been trained specifically to conduct assessments. *The Commission recommends preserving this flexibility within adequate federal guidelines, which at a minimum include requirements for adequate training.*

To ensure uniformity within and across states, *the Commission recommends that the assessment agency use standardized assessment criteria.* Such standardization is already in place in state programs that provide extensive home and community-based care.

In addition to the disability assessment, the federally certified agency would be responsible for the financial assessment of individuals requesting federal subsidies for copayments. At the appropriate time, it also would conduct the financial assessments of people with nursing home stays longer than three months to determine eligibility for public benefits. Conducting financial assessments in an agency that serves all beneficiaries, regardless of income, is consistent with the Commission's intent that the program avoid any welfare stigma.

Benefits and Financial Responsibilities

The kinds of public support people receive and the nature of their financial obligations would depend upon whether they are at home or in nursing homes. The administration of home care benefits under the Commission's plan is designed to tailor services to people's particular needs and preferences and to ensure that public resources are used as efficiently as possible. Nursing home benefits are designed to depend on how long people stay.

Home and Community-Based Care Benefits—Individuals determined to be severely disabled by the assessment agency would be eligible for the services they need to survive. Benefits are intended to complement support that families provide and to help disabled people continue functioning at the highest level of independence of which they are capable. Services would be available to severely disabled people living in board and care facilities and other types of assisted living as well as to those living in private residences.

The Commission recommends that public program benefits encompass at least the following: a broad range of personal care services including feeding, transferring, and tasks related to personal hygiene; homemaker/chore services (such as meal preparation, laundry, housework, transportation); *medication management; and,* for those who are able to leave their homes, *day care services* (for disabled adults and children).

In recognition of the immense burdens experienced by family caregivers, the *Commission recommends that the program cover respite services to provide them with some temporary relief.* Such relief would allow family members to take a much needed vacation, to meet unplanned obligations, or just to have a little time to themselves. Some caregivers desire in-home respite periodically; others prefer to place the disabled person in a nursing home for a brief period. Respite benefits, therefore, should be flexible and available in all settings. In addition, *the Commission recommends that the program cover training of family members in how to deliver home-based care more effectively and support counseling for family caregivers.*

Finally, *the Commission recommends that skilled nursing care as well as physical, occupational, speech, and other appropriate therapy services be covered.* Providing these benefits would not replace the current Medicare home health benefit; rather it would extend skilled services to persons not now eligible for Medicare.

Cost Sharing—The Commission believes that individuals who can contribute to the cost of their care should be expected to do so. *The Commission recommends that beneficiaries be required to contribute 20 percent of the actual costs of care or 20 percent of the national average cost of home and community-based care, whichever is lower, with federal subsidization for the poor and near-poor.* Since copayment would place a heavy burden on low-income individuals, the federal government would fully subsidize these costs for persons with incomes at or below the poverty level and partially subsidize them at least for those with incomes between 100 percent and 200 percent of poverty.

Managing and Allocating Care—The Commission is concerned that home care services support but not replace family caregiving and be managed in a fiscally responsible manner. *The Commission recommends reliance on case managers to develop and oversee individual care plans.* Case management is an effective way to allocate the appropriate types and amount of services, to help individuals navigate an often uncoordinated and unwieldy system, and to manage and monitor the care process. A comprehensive case management system addresses three major problems in financing and delivering long-term care—quality, access, and costs—and can be particularly useful for a population with multiple problems that cut across traditional service delivery systems.[4]

MARILU HALAMANDARIS/NATIONAL ASSOCIATION FOR HOME CARE

Commission recommendations ensure home care for the severely disabled to sustain their independence and support family caregivers.

In requiring case management, the intent of the Commission is to build on the experience that some states already have and to preserve the flexibility and creativity that exists. The Commission recognizes that case management can be designed in a number of ways.[5] Case management can be located in free-standing organizations not responsible for the service provision, or as part of a service-providing organization.[6] Some argue that case managers must remain independent of direct service delivery in order to avoid conflicts of interest and to choose the optimum service package without constraints. Advocates of the service provider approach, by contrast, suggest that those closest to the clients have the best perspective from which to make care planning decisions; that a case management/provider combination reduces administrative costs; and that this arrangement may facilitate better access to services.

The Commission does not prescribe a specific approach but recognizes that if case managers are to be located in provider agencies, safeguards must be built in to ensure the independence of the case manager in arranging and monitoring the plan of care. Audit by the assessment agency, described below, could provide that safeguard.

To ensure fiscal responsibility in the proposed public program, *the Commission recommends that the case manager operate within a budget set by the federal government.* The budget established under this program, in conjunction with other available services, should be sufficient to provide all services needed by the individual. To achieve this objective, per capita amounts would be set appropriate to the service needs of individuals at different disability levels (perhaps two or three levels). *The Commission recommends that the per capita amount for the most severely disabled level be set at a maximum volume of service or as a share of nursing home costs.*[7] Amounts below the maximum would be set for lower levels of disability. The total case management budget would then be the product of per capita amounts appropriate to the disabilities of a case manager's enrolled population, adjusted to reflect area costs and the number of enrollees.

Working within this budget, the case manager would develop a care plan tailored to the needs of the individual beneficiary. Where care is already being provided by family and friends, the intent is to supplement and reinforce rather than to replace this informal caregiving. States with experience in providing in-home services have built the formal plan of care around the core supports provided by families and friends, and have worked cooperatively with families in building the plan. *The Commission recommends that the case manager be free to allocate services to a client as needed within the budget. Expenditures for an individual's care, however, should not exceed the costs of care were the individual in a nursing home.*

In addition to care planning and service allocation, the case manager would be responsible for monitoring implementation of the care plan and conducting periodic reassessments to determine whether changes in the amount or type of services (including the need for nursing home placement) are warranted. While the Commission does not recommend a specific schedule, it notes that most programs undertake a formal reassessment with a home visit every six months, at least during the first year.[8]

For severely disabled nursing home residents returning home, the case manager would also facilitate the transition back into the community. Before the resident's discharge, the nursing home would be required to give reasonable notice to a case manager. The case manager would then assume the responsibility for assessing the needs of the individual and tailoring a home and community-based care plan.

To ensure adequate performance, *the Commission recommends that the assessment agency periodically audit the case managers.* Audits may address the purposes for which the dollars are spent, the appropriateness of service allocation, implementation of the care plans, and whether reassessments are done in a timely fashion.

Nursing Home Care—The Commission considers financing home and community-based care a top priority. At the same time, it acknowledges that not all persons enter a nursing home to die; many return home after relatively short stays and need resources to maintain their standard of living. Many more may be able to afford to return home if their financial resources are not consumed by the nursing home stay. The Commission's recommendations, therefore, extend social insurance to cover short nursing home stays.

The Commission recognizes that comprehensive social insurance for longer nursing home stays would allocate substantial public dollars to protect the estates of the wealthiest segment of the population. Given limited resources and the potential for these individuals to purchase private insurance, the Commission chose another approach. To protect moderate- and low-income individuals against the catastrophic costs of nursing home care, the recommendations include a government-provided floor of asset protection to eliminate the risk of impoverishment and leave most people's life savings intact.

The Commission recommends that those determined eligible for nursing home care by the federally certified assessment agency be entitled to coverage for the first three months of institutional care, with each three-month period of coverage considered an episode of care. Benefits would include custodial care as well as skilled nursing services for persons not receiving those services from Medicare. The Commission does not recommend a specific lifetime limit on the number of episodes to be covered. But it considers a maximum eligibility for two or three episodes to be plausible, each interrupted by a reasonable period of time (perhaps six months) to ensure that the program does not become a revolving door.

As with social insurance coverage for home and community-based care, front-end nursing home coverage would not be free. *The Commission recommends that all individuals be required to contribute 20 percent*

EARL DOTTER

Under the Commission plan, people needing nursing home care would be protected no matter how long they stayed.

of the actual costs of care, or 20 percent of the national average cost of nursing home care, whichever is lower, with federal subsidization for the poor and near-poor. The federal government would fully subsidize this copayment for individuals with incomes at or below the federal poverty level, and partially subsidize it at least for those with incomes between 100 percent and 200 percent of poverty.

The Commission believes that no severely disabled person should have to exhaust life savings and face the stigma of a welfare program in order to get coverage for longer stays in a nursing home. *For individuals with nursing home stays of more than three months, the Commission recommends establishing a floor of asset protection and more generous income protection than is available under current law to ensure that no individual or noninstitutionalized spouse faces impoverishment. For those who meet the disability criteria, this program would replace the welfare-based Medicaid program.*

Single individuals would be allowed to keep $30,000 and couples $60,000 in non-housing assets. Three out of five current elderly individuals would be immediately eligible for benefits at these asset levels. Over time, the Commission expects that eligibility levels would be adjusted to sustain that scope of protection.

These recommended levels would be a vast improvement over current Medicaid rules, which require single persons to spend down their non-housing assets to $2,000. The Medicare Catastrophic Coverage Act of 1988, in a provision still in effect, did improve the asset protection for noninstitutionalized spouses, setting a minimum resource allowance at $12,000, and allowing spouses to keep half of assets up to $60,000.[9] The recommended program, however, would set the *floor* for spousal assets at $60,000. Individuals with non-housing assets in excess of the levels protected by the program would be required to liquidate these resources and use them to finance their nursing home care before becoming eligible for program benefits. A case example of how this program would affect one individual appears on the next page.

The Commission recommends that individuals with long nursing home stays be required to contribute income toward the costs of this nursing home care, after certain portions of income are protected.

The program would allow single individuals to keep 30 percent of their monthly income for the first year of their nursing home stay so that they can maintain their homes in the community. Married persons would be eligible for this housing allowance as long as the community spouse were alive. This allowance is designed primarily for people who are likely to return to the community and have housing costs that must continue to be met—such as mortgage payments, property taxes, rent and condominium fees, and home repairs—during their nursing home stay. *The program would also provide a personal needs allowance of $100 per month to the person in the nursing home,* which is a vast improvement over the typical $30 per month currently available under Medicaid.

Finally, *the program would improve the spousal income protection provided by the Medicare Catastrophic Coverage Act.* Under current law, states are required to set aside a sufficient amount of the institutionalized spouse's income to raise the community spouse's income to 122 percent of the federal poverty level for a couple; up to 133 percent of this level as of July 1, 1991; and up to 150 percent of this level as of July 1, 1992. *The Commission recommends raising the minimum spousal income protection to 200 percent of the poverty level for a couple.* In 1990, this would protect $16,900 for the spouse. Any remaining income would go toward the cost of the nursing home care.

Financing Long Nursing Home Stays: The Commission Plan Compared with Current Law—A Case Example

Sally Dowd is 78 years old and needs nursing home care. She has life savings of $30,000 and some equity in her house, which she owns. Her income, from social security and her own and her late husband's pensions, totals $1,800 a month. The nursing home into which she is moving costs $24,000 a year, or $2,000 a month.

Current law. Ms. Dowd would be required to "spend down" $28,000 of her assets—14 months' worth of nursing home care—before Medicaid would help pay the cost of her care. She could then retain a $30 a month personal needs allowance (PNA), and would have to contribute $1,770 per month toward the cost of her care. Medicaid would pay the $230 per month balance.

Commission plan. For the first three months of her stay, Ms. Dowd would receive benefits without regard to her income or assets. She would be responsible for coinsurance of $400 a month—20 percent of the cost of the care. If she stays beyond three months, she would contribute more. But her life savings and some of her income would be protected. For one year, she could retain $100 a month for a PNA, and $540 a month (30 percent of her income) to help maintain her home. The remaining $1,160 of her income would go toward the cost of care. If she stayed beyond this period, she would retain only the $100 PNA, with $1,700 per month going toward the cost of care.

Her life savings would never be affected by her participation in the program.

Financing of the Public Plan

The recommended social insurance for home and community-based care and the first three months of nursing home care would provide the same protection for the long-term care needs of individuals, regardless of income, that Medicare provides for health care needs. The Commission believes that the federal role for the financing of Medicare is also appropriate for the proposed program and, therefore, *recommends that the federal government be financially responsible for the social insurance components of the public plan.*

The federal and state governments would share the financial responsibility for the part of the program that covers longer nursing home stays. However, to protect states from the sizable costs of expanding their current programs, *at the outset states would be required to contribute only the amounts they now spend on Medicaid for long-term care.* The federal government would bear the costs of expanded eligibility, services, and payment rates. The states and the federal government would jointly finance annual increases in expenditures similar to the way they share financing under Medicaid. Matching rates could be adjusted to reflect the long-term care needs of a state—as indicated by the size of the state's elderly population.

Administering the Public Plan

To promote flexibility to meet the needs of a heterogeneous population, while ensuring equity across states, *the Commission recommends that the federal government contract with the states to administer the public plan. The federal government would be responsible for setting guidelines and adequate standards for this administration.*

As noted above, the federal government would certify the assessment agencies and develop standardized assessment criteria for determining eligibility for home and community-based care and nursing home care under the public plan. In addition, the federal government would establish guidelines for certifying case managers to ensure adequate training and the capacity to undertake the assessment, service allocation, and monitoring functions, and for quality assurance.

As described previously, the federal government would be responsible for determining the case manager budgets. *Provider payment rates for both home and community-based care and nursing home care would also be determined at the federal level.* Federal rate determination is intended to ensure payment adequate for access to quality care, efficiently provided, in all parts of the country. For nursing home care, many states have extensive experience with prospective payment systems, some of which include sophisticated design to reflect resident characteristics and to foster efficient delivery of care.[10] These systems can provide guidance in developing a federal approach.

For home care, the federal government is beginning to experiment with prospective payment methods to replace the cost-based system now in use for Medicare home health care. However, services covered by the Commission's plan would go well beyond the nursing, rehabilitation, and aide services that constitute the bulk of home health care. States providing home and community-based care use a variety of payment methods, including fee schedules or price lists and competitive bidding. Federal guidelines could build on this experience.

Within these federal guidelines, *the Commission recommends that the states be given leeway in administering the public plan.* Where long-term care programs already exist, states should build on the current infrastructure for the coordination, management, and delivery of services. In states where the long-term care programs are less developed, the design and implementation of a system would take time. The Commission recommendation provides an opportunity for creativity and experimentation. The Commission expects the standards and guidelines established by the federal government to help less-developed states build their infrastructure to address the unique needs of their communities.

Existing state programs use a variety of providers to deliver home and community-based care services, including agencies, independent contractors employed directly by individuals, and even family caregivers. Given this wide variation, *the Commission recommends that the states certify the providers who participate in the public plan, in accordance with federal guidelines.*

A review and appeals process is necessary in order to protect clients' rights to due process with respect to denial and termination of benefits. *The Commission recommends that the states be given responsibility for developing a review and appeals process, subject to federal guidelines.* Elements from review and appeals processes in current health and disability programs such as Medicare, Medicaid, and Social Security disability could be incorporated into the design of procedures for this new public program.[11]

Ensuring Quality and Containing Costs

The Commission recognizes that considerable federal and state effort would be required to ensure adequate quality in long-term care. For nursing homes, the Commission believes that the recently enacted reforms in requirements for care and in measures for enforcing compliance would provide a firm foundation for quality assurance for broader nursing home coverage.

For home care, quality assurance mechanisms are less well developed. Inherent in the Commission's design of the home care program are several mechanisms for ensuring quality of care. The federal standards and guidelines the Commission calls for to assess eligibility, as well as certify assessment and case management agencies, are designed primarily to help ensure quality—with a particular emphasis on adequate training. Furthermore, case management itself is an important part of any quality assurance mechanism. In preparing the individual care plan, arranging for services, and conducting periodic reassessments, the case manager frequently develops a personal relationship with the client and family. The case manager thus has the opportunity to monitor the quality of the services being provided formally and informally in the home. The auditing function of the federally certified assessment agency over the case manager decisions provides an additional quality check.

Federal standards already exist for ensuring the quality of care provided by Medicare home health agencies. Broader standards for certified providers, however, would be needed as the program expands services. Voluntary accreditation programs available through professional or trade associations could help guide the development of standards for home care providers other than home health agencies. Standards are likely to be most effective if they focus on ensuring client participation and clients' rights, use indicators of quality that include both outcome and process measures, monitor personal care and supportive services, and ensure continuity of care and appropriateness of services.[12]

Other mechanisms to ensure quality would also be needed. At the state level, long-term care ombudsman offices mandated by the Older Americans Act are already required to monitor the quality of care in both nursing homes and board and care homes.[13] Ombudsmen are also among the mechanisms some states are using to ensure quality in home and community-based care, and can be encouraged and supported to undertake this task.[14] Other mechanisms could include auditing providers at the point of service, awarding service contracts based on the providers' history of quality service (using past compliance reviews and documented complaints), and establishing quality assurance committees to conduct periodic random reviews of client cases.

The Commission is also concerned that the long-term care system operate in a way that ensures adequate access to quality care, without excessive costs. Case management budgets are designed explicitly to control expenditures and promote efficient allocation of services. Provider payment mechanisms would similarly be designed to promote efficient service delivery. As noted above, states' experience with nursing home payment provides considerable guidance on how to design payment mechanisms for this purpose, and experience on home care is developing.

Although the Commission does not endorse a specific payment mechanism for nursing homes, it recognizes that access to quality care would require higher rates than many Medicaid programs now pay. Prospective payment mechanisms could be employed to control rates of increase over time. In addition, adequate access could require some increase in the supply of nursing home beds. Over time, the Commission intends that payment methods or other mechanisms be used to ensure an adequate but not excessive supply of beds.

Integration with Existing Federal Long-Term Care Programs

The recommended new public program of long-term care for the severely disabled would overlap with current programs. The recommended nursing home benefits are intended to replace the Medicaid program for people who are severely disabled, as defined by the Commission. Nursing home care financed by Medicaid, however, may continue to be necessary for residents of intermediate care facilities for the mentally retarded who do not satisfy eligibility criteria.

By contrast with Medicaid, the recommended nursing home benefits would expand current Medicare benefits for nursing home care. Medicare would become the first payer for nursing home users who qualify for its skilled care. The recommended social insurance would cover stays lasting beyond the point Medicare pays for coverage, up to a total of three months of care.

With respect to home and community-based care, the proposed social insurance program would replace all the Medicaid programs that currently fund home health and home care services for those who are severely disabled as defined by the Commission. Medicaid programs would remain intact for the less severely disabled who meet the current financial standards, however. As with nursing home care, the new program would not replace Medicare's role in covering skilled home health care.

The Commission recognizes that not all individuals who need long-term care would be eligible for benefits under its recommendations. In addition, it recognizes that some people who would be eligible for long-term care services might need specialized care that the program would not cover. Most notable in this regard are the developmentally disabled and chronically mentally ill, for whom assistance in basic functions addresses only some critical needs. Consequently, implementation of the Commission recommendations assumes the continuation of services provided by, for example, the veterans' health system, Title III of the Older Americans Act, the Social Services Block Grant, and numerous programs for the chronically mentally ill and developmentally disabled. The case manager would be responsible for coordinating services across programs.

Phase-In Schedule for the Public Program

The Commission recommends that the public program be phased in over a period of four years. The Commission recognizes that development of a new program, particularly the home and community-based care component, must inevitably take time. Incremental steps are necessary to allow the federal and state governments to move toward full implementation in an orderly fashion.

Year One—The home and community-based care program would begin by making a limited amount of care (200 hours per person per year, for instance) available to all severely disabled persons.

Year Two—The three-month, front-end nursing home care benefit would be made available to individuals entering nursing homes and coverage for longer nursing home stays would be put into place. Nursing home reimbursement rates would begin to be improved.

Year Three—The amount of home and community-based care services available would be expanded (to 400 hours per person per year, for instance).

Year Four—The home and community-based care program would be fully implemented, and further improvements in nursing home reimbursement rates would take place.

THE ROLE OF PRIVATE LONG-TERM CARE INSURANCE

The Commission believes that private insurance for long-term care can play a valuable role in supplementing coverage provided by the public program. Many people would want to purchase private insurance to cover cost sharing for home care and short nursing home stays and to protect additional income and assets in case of long nursing home stays. *The Commission, therefore, recommends specific measures for the promotion and regulation of private long-term care insurance.*

To encourage the purchase of long-term care insurance and, in particular, employer sponsorship of such insurance, *the Commission recommends clarifying the tax code so that long-term care is explicitly defined as appropriate for preferential treatment.* The Commission's recommendations cover free-standing long-term care insurance policies, as well as long-term care riders applied to other policies like life insurance.

The tax code currently defines neither long-term care nor long-term care insurance. The tax treatment of premiums paid and benefits received is, therefore, unclear.[15] *The Commission recommends that long-term care insurance premiums paid and benefits received be treated the same as health insurance.* This recommendation would enable employers to pay for long-term care insurance without obligating the employee to include premiums or benefits as taxable income.[16]

The Commission also recommends that long-term care insurance be explicitly excluded from the definition of deferred compensation when used in conjunction with an employer's cafeteria plan (Section 125 plan). Except for retirement savings plans, the tax code does not allow employers to include other forms of deferred compensation in a cafeteria plan. The Commission's recommendation would allow employers to include long-term care insurance in employee cafeteria plans.

These changes or clarifications in the tax code would give long-term care the same tax preferences as health insurance, pensions, and other employee benefits. With this equal footing, employee demand and employer preferences for long-term care insurance as an employee benefit would no longer be impeded by tax law discrepancies relative to other benefit choices.

Qualification for preferential tax treatment, however, along with general concerns about adequacy, would necessitate that insurance policies meet minimum standards. The Commission seeks to ensure that abuses that have plagued the Medigap market not be repeated in long-term care. Development and enforcement of minimum standards, therefore, are essential. *The Commission recommends regulation of long-term care policies by the states, using federal or stricter standards.* Standards would address at a minimum benefits that must be covered, administration of policies, sale of policies, funding of reserves for policies, nonforfeiture values, and the portability of benefits. These standards could build upon the model regulations of the National Association of Insurance Commissioners.

To promote enforcement of standards, *the Commission recommends that the federal government encourage states to strengthen civil penalties for misrepresenting policy standards, knowingly selling duplicative insurance, or marketing unapproved policies by direct mail.*

The Commission further recommends special assistance to consumers in assessing long-term care policies. Specifically, the federal government would establish methods of disseminating to consumers unbiased, professional information regarding private long-term care policies. States would be expected to train benefits specialists regarding private long-term care insurance and the availability of state information on that insurance.

RESEARCH AGENDA

At the same time as the Commission recommends development of a comprehensive program to cover long-term care, it also recognizes the importance of research on ways to prevent the conditions that create the need for long-term care, on the kinds of services most likely to enhance people's capacity to function, and on program management tools and delivery systems that promote efficient delivery of quality care.

The Commission recommends that the federal government move aggressively to contain costs and mitigate human suffering by funding a research and development program aimed at preventing, delaying, and dealing with long-term illnesses and disabilities. That effort should move toward a funding level of $1 billion annually and should do the following:

- Explore how to reduce the risk for certain physical and mental disorders (such as Alzheimer's disease, osteoporosis, and urinary incontinence) that are associated with increased need for long-term care;
- Examine the special long-term care problems of subpopulations, such as disadvantaged racial and ethnic minorities and the rural elderly and nonelderly disabled;

- Develop outcome measures and national practice guidelines in long-term care;
- Improve functional assessment tools to target services better to populations in need of care;
- Examine how to enhance the quality of long-term care including integration of services and case management;
- Evaluate the implementation of home and community-based care.

BENEFICIARIES AND COSTS OF COMMISSION RECOMMENDATIONS

The Commission's recommendations provide a blueprint for developing a national long-term care system. Home and community-based care, now limited in most communities and virtually nonexistent in many, would be available and affordable. The choice between care at home or care in an institution would increasingly depend on people's needs and preferences, rather than their resources. People who need nursing home care for short periods would have their resources preserved intact to return home. No one would have to fear impoverishment from ending life in a nursing home. People would contribute to the costs of care for all services subject to their ability to pay, and would have broader access to private insurance to cover those costs.

All Americans would be beneficiaries of the new public program, for it provides everyone—most especially the elderly and their families—peace of mind in the face of long-term care needs.

But we cannot build a system that ensures adequate service to people who need it merely by shifting around the dollars we spend today. Long-term care is expensive. Nursing homes cost over $2,500 per month, and home care can exceed $60 a visit. Substantial new expenditures would be required to provide more people better services. People likely to purchase care under current rules would face substantially lower out-of-pocket expenses, however. And new purchasers would share expenses with the public program, so that their burdens would be limited.

If the program were in place today, it would serve 4.4 million people at a net new federal cost of $42.8 billion—$24 billion for care at home and $18.8 billion for nursing home care (see Table 4-1).[17, 18, 19] About three-quarters of total spending would go to the elderly, about a quarter to people under age 65.

For the severely disabled elderly, new federal spending would be split almost evenly between home care and nursing home care ($15 billion and $16.8 billion, respectively). For nursing home care, the floor of protection against impoverishment would cost an estimated $11.3 billion; broader protection for short stays would cost an additional $5.5 billion. For younger severely disabled, most of whom live in the community, almost all new spending ($9 billion out of a total $11 billion) would go to home and community-based care. The costs of phasing in the program are shown in Table 4-2.

For the elderly, data allow a more detailed look at the difference the program would make to people using long-term care. Under the new program, 2 million severely disabled elderly people at home are estimated to use care—double the number who now use paid care. For the 1 million who would have purchased their own care in the absence of the public program, out-of-pocket savings are estimated to be $900 million—about $1,000 per user.

Under current programs, roughly 1 million people are expected to enter nursing homes during 1990, almost 40 percent of whom will receive no public support. Because more people would have access to better nursing home care under the Commission's program, the number of people using a nursing home is

Table 4-1 Beneficiaries and Net Federal Costs of Commission Long-Term Care Recommendations, by Age Group and Type of Service

	Home Care	Nursing Home Care	Total
Total Beneficiaries (In Millions)			
Elderly	2.0	1.2	3.2
Nonelderly	1.0	.2	1.2
Total	3.0	1.4	4.4
New Federal Costs (In Billions, 1990)			
Elderly	$15.0	$16.8	$31.8
Nonelderly	9.0	2.0	11.0
Total	$24.0	$18.8	$42.8

SOURCE: For elderly, Lewin/ICF estimates using the Brookings/ICF Long-Term Care Financing Model; for nonelderly, Commission staff estimates.

Table 4-2 Phase-In Schedule and Cost of Commission Long-Term Care Plan

(1990 Dollars) *

Year 1	
Provide limited home care benefit to all eligible persons **	
New federal cost	$10.8 billion
Year 2	
Provide initial three-month nursing home benefit	
Provide benefit for longer nursing home stays	
Begin to improve nursing home reimbursement, relative to Medicaid rates	
Additional federal cost from Year 1	$14.2 billion
Cumulative new federal cost, Years 1–2	25.0 billion
Year 3	
Expand home care benefit **	
Additional federal cost from Year 2	$7.8 billion
Cumulative new federal cost, Years 1–3	32.8 billion
Year 4	
Fully implement the home care program **	
Further improve nursing home reimbursement	
Additional federal cost from Year 3	$10.0 billion
Home care:	$5.4 billion
Nursing home care:	$4.6 billion
Cumulative new federal cost, Years 1–4	**$42.8 billion**
Home care:	$24.0 billion
Nursing home care:	$18.8 billion

* Cost estimates are presented as if each phase were fully implemented in 1990. Costs are not adjusted to reflect inflation or cost containment savings.

** The full costs of the home care benefit reflect a budget based on a per capita payment that varies with participants' disability levels. Cost estimates assume that per capita payment for the most severely disabled would cover 1,300 hours of service per year, with lesser amounts for less severely disabled categories. Benefits would be phased in by limiting the volume of services provided to eligible individuals to lesser amounts—to 200 and 400 hours in Year 1 and Year 3, respectively.

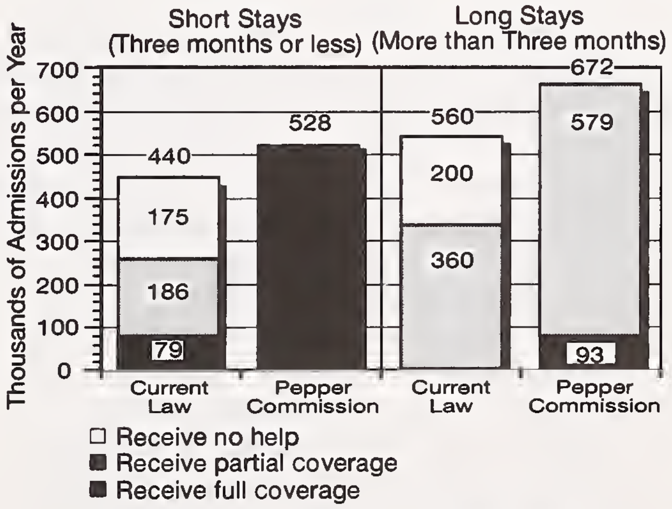
expected to increase. Under the recommended program, about 1.2 million people are expected to enter a nursing home in a year; all would receive some public support. People who would have used a nursing home at their own expense or spent down to Medicaid in the absence of the new program would save $6.9 billion in out-of-pocket expenses, about $3,000 per user.

Figure 4–1 shows how coverage under the Commission's recommendations would improve nursing home protection, relative to protection current programs provide. Under the recommended new public program, all 1.2 million nursing home entrants would receive coverage for the first three months of nursing home care. For almost half of all entrants (528,000 people), the three-month social insurance benefit would cover their entire nursing home stay. Financial obligations would be limited to cost sharing requirements, subsidized for low-income people. People would have their resources intact, should they be able to return home. Today, less than 20 percent of short-term nursing home entrants (79,000 people) get equivalent coverage—the minority who satisfy Medicare's skilled care requirements and who receive the full Medicare benefit for the duration of their stays. Forty percent of people who enter nursing homes for short stays (175,000 entrants) receive no assistance from today's public programs. The rest get help from Medicare for part of their stay or are sufficiently impoverished to qualify for Medicaid support.

Short stays, though common and expensive for the elderly, are not the source of their greatest fears. What elderly people and their families most dread is that they will end their days in nursing homes, exhaust the savings of a lifetime, and be forced to rely on welfare. The Commission's recommendations for covering long stays would end that fear by establishing a floor of protection against impoverishment. Three-quarters of nursing home entrants who stay beyond three months (504,000 entrants) would benefit from this protection: an estimated 93,000 entrants who would have full income and asset protection; an additional 332,000 entrants who would have assets fully protected no matter how long they stayed; and 79,000 entrants who would acquire asset protection over the course of their stay. Another 168,000 entrants with stays exceeding three months would receive benefits only for the first three months of their stay (see Table 4–3).

This protection contrasts sharply with current programs. Today, protection for "long-stayers" is provided almost solely through Medicaid, and only after

Figure 4-1 How Elderly Nursing Home Entrants Benefit from Commission Plan, Compared with Current Law



SOURCE: Commission staff analysis based on Brookings/ICF Long-Term Care Financing Model.

Table 4-3 Coverage for Elderly Nursing Home Entrants with Long Stays Under Commission Plan

(In Thousands of People)

Benefits for first three months only		168
Benefits beyond three months		504
Full income and asset protection	93	
Full asset protection	332	
Partial asset protection	79	
Total admissions covered		672

SOURCE: Lewin/ICF estimates using Brookings/ICF Long-Term Care Financing Model.

all assets and income are exhausted. For 200,000 entrants with long stays, there is no public support at all.

People of all income levels would be helped by the Commission's recommendations. However, severely disabled people tend to have low incomes. Based on current patterns of service use, an estimated 89 percent of beneficiaries would have incomes below 200 percent of the poverty level (see Figure 4–2).

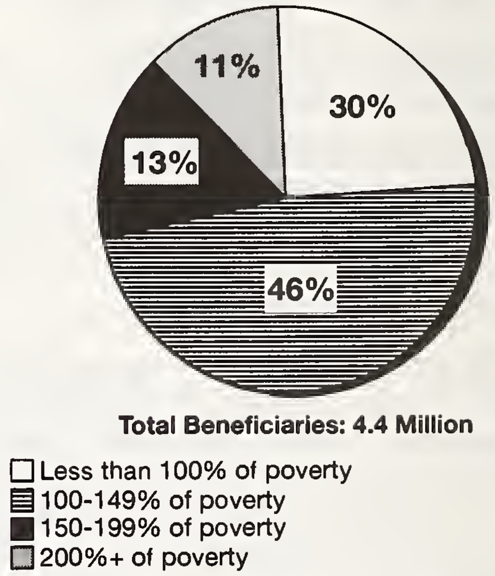
Under the new public program, people would no longer be expected to devote all their resources to long-term care before they could receive public support. However, all but the poorest would be expected to contribute to the costs of care. Under the new program individuals would be responsible for about $12 per home care visit or—for short stays—about $15 per nursing home day. For long nursing home stays, they would contribute income and assets above protected levels.

The Commission recommendations would facilitate the purchase of private insurance to cover these expenses through assistance and oversight to ensure adequate policies and through favorable tax treatment for policies purchased. If employers contribute substantially to premiums for long-term care coverage, favorable tax treatment would mean a loss of revenues the federal government would otherwise receive. In the short term, however, employers are not expected to contribute. Uncertainties make it difficult to calculate what tax expenditures would be over the long term.

This count of people and dollars significantly understates the benefits the recommended long-term care coverage would bring. Families of the severely disabled would receive badly needed help in caring for their impaired loved ones. Employed caregivers, or caregivers who could be employed, would be better able to balance responsibilities at home and on the job. Employers would reap the benefits of a more secure and productive work force.

Finally, and perhaps most important, all Americans would benefit from the security of knowing that if the need for long-term care should arise—for themselves, their parents, or their children—they would not be left to cope on their own. The nation would have a system to which everyone in need could turn for help.

Figure 4-2 Number of Beneficiaries of Commission Long-Term Care Plan, by Income Relative to Federal Poverty Level



SOURCE: Lewin/ICF estimates using the Brookings/ICF Long-Term Care Financing Model.

Notes to Chapter 4

1. Laura Himes Iversen, *A Description and Analysis of State Pre-Admission Screening Programs* (Report prepared by Interstudy, Center for Aging and Long-Term Care: Excelsior, Minn., March 1986).

2. Diane Justice, *State Long-Term Care Reform: Development of Community Care Systems in Six States* (Washington, DC.: National Governors Association, 1988), 75–78. [Hereinafter cited as Justice, *State Long-Term Care Reform.*]

3. Exceptions to eligibility criteria may be necessary to deal with some individuals in the future who may be determined to need nursing home care but fail to meet the disability criteria. People in nursing homes when the program begins could apply immediately for the income and asset protection benefits for long-stayers, regardless of their length of stay.

4. Rosalie A. Kane et al., *Case Management Costs: Conceptual Models and Program Descriptions.* (Final Report prepared at the University of Minnesota Health Policy Center under a grant from the Health Care Financing Administration, June, 1989). [Hereinafter cited as Kane et al., *Case Management Costs.*]

5. Office of Technology Assessment, "Case Management," in Pepper Commission, *A Call for Action,* Supplement to the Final Report (Washington, D.C.: Government Printing Office, 1990).

6. One recent study of 48 case management programs (Kane et al., *Case Management Costs*) found that 56 percent of the programs also provide some direct services.

7. Cost estimates assumed a maximum 25 hours of care per week for the most severely disabled.

8. Kane et al., *Case Management Costs.*

9. Under current Medicaid law, states may choose to set the floor as high as $60,000, and 13 states have chosen to improve this floor of protection. U.S. Congress, House Committee on Energy and Commerce, Subcommittee on Health and the Environment, *Medicaid Source Book: Background Data and Analysis,* report prepared by the Congressional Research Service, 100th Cong., 2d Sess., 1988, Committee Print 100–AA.

10. John Holahan and Joel Cohen, "Nursing Home Reimbursement: Implications for Cost Containment, Access and Quality," *Milbank Quarterly* 65 (1987): 112; Judith Feder and William J. Scanlon, "Juggling Goals in Nursing Home Reimbursement Policy" in *Affording Access to Quality Care: Strategies for State Medicaid Cost Management,* eds. Richard Curtis and Ian Hill (Washington, D.C.: National Governors Association, Center for Policy Research and Analysis, July 1986), 31.

11. For a detailed review of review and appeals processes in current federal programs and their implications for developing a long-term care program, see Jane Yurow, "Due Process: Review and Appeal Procedures in Long-Term Care," in Pepper Commission, *A Call for Action,* Supplement to Final Report (Washington, D.C.: Government Printing Office, 1990).

12. Patricia A. Riley, *Quality Assurance in Home Care* (Report prepared for the American Association of Retired Persons, Washington, D.C., February, 1989).

13. Judith Feder, Jennifer Edwards, and Susan Kidder, *The Long-Term Care Ombudsman Program: Efforts and Limitations in Quality Assurance.* (Working paper No. 649–4 prepared at the Center for Health Policy Studies, Georgetown University, Washington, D.C., June 1990).

14. Justice, *State Long-Term Care Reform.*

15. Clarifying the tax treatment of premiums paid and benefits received should not be understood to preclude clarifying the tax treatment of long-term care insurance reserves. Prior to April 10, 1989, the earnings on long-term care insurance reserves were also ambiguous. However, IRS Revenue Ruling 89–43 indicated that long-term care insurance reserves would effectively receive the same tax treatment as life-insurance reserves.

16. Incorporated employers can already deduct their cost of providing long-term care insurance to their employees. The recommendation to make the treatment of long-term care insurance the same as health insurance, in conjunction with the recommendation to allow unincorporated employers to deduct the full cost of their own health insurance premiums (see Chapter 2), would imply that self-employed and unincorporated firms can also deduct the full cost of long-term care insurance.

17. For methodology used in determining these estimates, see Appendix E "Assumptions Used to Estimate Costs for Long-Term Care Recommendations."

18. Over 80 percent of the new federal cost of the program would be new costs, that is, not offset by savings. This is because there would be so many new users of home care services and because of the increased use and higher payment rates for nursing homes.

19. Estimates for costs and use of services presented here are based on the Brookings/ICF Long-Term Care Financing microsimulation model for the elderly. Data on the nonelderly are too limited to include in the model. Estimates of expected total federal expenditures are developed by applying changes in use estimated for the elderly to the nonelderly population as well. Also estimates are based on 1989 costs applied to the population in 1993. To simplify the discussion it is assumed that this approximates 1990 costs applied to the population in 1990.

Chapter 5

Revenues to Finance Commission Recommendations

Chapter 5

Revenues to Finance Commission Recommendations

The estimated new federal cost of the Commission's recommendations on health care and long-term care for people of all ages would be about $69.6 billion if fully implemented in 1990. Although some of these funds could be raised from reductions elsewhere in the federal budget, the Commission recognizes that new revenues will be necessary. Financing the program costs entirely through new taxes in 1990 would require $430, on average, from each nonpoor American adult. Different tax packages would spread the burden in different ways.

The Commission recommends that three criteria guide the selection of options for raising these revenues.

- *Taxes should be progressive, requiring a higher contribution from those most able to bear increased tax burdens.*
- *Revenues should be able to grow fast enough to keep up with benefit growth.*
- *Contributions should come from people of all ages.*

PROGRESSIVE TAXES

Different taxes distribute the burdens on taxpayers in different ways. Taxes are measured by their "progressivity." The more progressive the tax, the greater the share of income wealthier people must pay compared with those who earn less. By contrast, a "regressive" tax requires a greater share of income from lower-income people. Raising income tax rates for the wealthier, for instance, is highly progressive. On the other hand, imposing a sales tax on an item like food, which would place a greater burden on the poor, is regressive.

The justification for using a progressive tax rests on the premise that people with greater ability to pay should contribute more to government programs.

GROWTH

The extent to which revenue sources can be expected to grow over time varies. Costs for the program recommended by the Commission will rise as the population expands and ages, and as benefit costs increase. Choosing taxes that yield sufficient revenues to cover this growth avoids uncertainty about whether new taxes would be necessary or tax rates raised. Taxpayers would therefore have a predictable set of tax requirements. Furthermore, predictable growth in revenues provides a foundation for cost containment efforts. To cover program costs, revenues should increase by at least 8 percent to 9 percent annually. (This rate assumes full program implementation.)

CONTRIBUTIONS FROM EVERYONE

Because the Commission's recommended program would benefit everyone—the young and the old, workers and unemployed—all types of taxpayers should be asked to contribute to program costs. Taxes vary in the degree to which they are comprehensive—that is, inclusive of everyone. Specific excise taxes, for example, may not be comprehensive, since they primarily affect those with certain consumption patterns. The income tax, by contrast, is more comprehensive because it includes a wide range of income sources in its base. Using comprehensive revenue sources would help ensure that the scope of revenue sources matches the scope of the benefits—that Americans of all ages contribute to the proposed health and long-term care programs, just as all Americans would benefit from them.

REVENUE SOURCES AND OPTIONS

Possible taxes that could be used to finance the Commission's health and long-term care recommendations are listed in Appendix F. The list is illustrative rather than all-inclusive, and compares the amount of revenue likely to be raised from various sources. It also indicates how well each revenue source meets the Commission's three recommended criteria.

As a practical matter, any revenue package—or revenue option—must include at least one broad-based source: either an increase in the income or payroll tax rate, or the addition of a new source such as a value-added tax.

In constructing a revenue option, it may be important to begin with a broad-based source, and supplement it with other sources to enhance progressivity, comprehensiveness, and growth potential. A payroll tax, for instance, is neither very progressive nor fully comprehensive. Other tax sources could be combined with a payroll tax increase, however, to bolster these missing attributes in a final revenue option.

Options can be developed by combining various revenue sources. In some instances, however, the combination of several sources could yield more—or less—than the sum of the components. This is particularly true of the income tax options.

Broadening the income tax base *and* raising the rates, for example, would probably yield more total revenues than implied by simply adding the two estimates. Combining two or more of the income tax rate changes, by contrast, might produce smaller revenues than implied by adding the estimated revenues.

Finally, care should be taken in generalizing these estimates beyond the amounts presented in the appendix. It is incorrect to assume, for instance, that doubling the increases in payroll or excise tax would yield twice the amount of revenue. Substantially higher tax rates could cause behavioral changes that would result in smaller increases in revenue yields.

Appendix F illustrates various ways that revenue sources might be combined to finance Commission recommendations. Each option lists several revenue sources—including, in some instances, reductions in other spending areas—that could raise the money needed to finance implementation of the Commission's recommendations—about $70 billion to $75 billion.

Each option satisfies, in varying degrees, the Commission's criteria for judging potential revenue sources: progressivity, capacity for growth over time, and contributions from everyone. Each package also builds around a broad-based tax that raises most of the revenue. Other elements in the package were selected to compensate for shortcomings in the primary revenue source, as judged against the Commission's criteria. The analysis in Appendix F demonstrates how each package would apportion the financing burdens across people with different incomes, ages, family size, and other characteristics.

The Commission does not endorse a particular option or the elements that comprise the option. Other revenue sources or combinations might reasonably be considered. Rather, the Commission has presented options to illustrate alternative ways to raise the revenues needed for program implementation.

Vote Tallies and Commissioners' Views

Vote Tallies

On March 2, 1990, the Pepper Commission held its final meeting and voted on recommendations regarding access to health care and long-term care and principles for financing these recommendations. A vote on recommendations for health care for the elderly was conducted through the mail and completed on July 20, 1990. The Commissioners' votes on all of these were as follows:

RECOMMENDATIONS ON ACCESS TO HEALTH CARE FOR THOSE UNDER AGE 65 (Approved 8 to 7)

Voting in favor:	*Voting against:*
Mr. Balog	Mr. Baucus
Dr. Davis	Mr. Cogan
Mr. Kennedy	Mr. Durenberger
Ms. Oakar	Mr. Gradison
Mr. Pryor	Mr. Heinz
Mr. Stokes	Mr. Stark
Mr. Waxman	Mr. Tauke
Mr. Rockefeller	

FINANCING FOR NONELDERLY HEALTH CARE RECOMMENDATIONS (Approved 8 to 7)

Voting in favor:	*Voting against:*
Mr. Balog	Mr. Baucus
Dr. Davis	Mr. Cogan
Mr. Kennedy	Mr. Durenberger
Ms. Oakar	Mr. Gradison
Mr. Pryor	Mr. Heinz
Mr. Stokes	Mr. Stark
Mr. Waxman	Mr. Tauke
Mr. Rockefeller	

RECOMMENDATIONS ON ACCESS TO FOR THE ELDERLY (Approved 11 to 4)

Voting in favor:	*Voting against:*
Mr. Balog	Mr. Cogan
Mr. Baucus	Mr. Gradison
Dr. Davis	Mr. Stark
Mr. Durenberger	Mr. Tauke
Mr. Heinz	
Mr. Kennedy	
Ms. Oakar	
Mr. Pryor	
Mr. Stokes	
Mr. Waxman	
Mr. Rockefeller	

RECOMMENDATIONS ON ACCESS TO LONG-TERM CARE (Approved 11 to 4)

Voting in favor:	*Voting against:*
Mr. Balog	Mr. Cogan
Mr. Baucus	Mr. Gradison
Dr. Davis	Mr. Stark
Mr. Durenberger	Mr. Tauke
Mr. Heinz	
Mr. Kennedy	
Ms. Oakar	
Mr. Pryor	
Mr. Stokes	
Mr. Waxman	
Mr. Rockefeller	

FINANCING FOR LONG-TERM CARE RECOMMENDATIONS (Approved 11 to 4)

Voting in favor:	*Voting against:*
Mr. Balog	Mr. Cogan
Mr. Baucus	Mr. Gradison
Dr. Davis	Mr. Stark
Mr. Durenberger	Mr. Tauke
Mr. Heinz	
Mr. Kennedy	
Ms. Oakar	
Mr. Pryor	
Mr. Stokes	
Mr. Waxman	
Mr. Rockefeller	

1838

INVESTMENT ADVISORS L.P.

James Balog

CHAIRMAN

August 13, 1990

Senator John D. Rockefeller, IV
Chair
The Pepper Commission
140 Cannon House Office Building
Washington, DC 20515

Dear Mr. Chairman:

First, I wish to express my admiration to you on a job well done. My admiration extends especially to your persistence in keeping the Commission moving toward satisfying its goal. Clearly, the task was formidable, and the members arrayed along a broad spectrum of ideas, with each responding to different experiences and constituencies. But the charter of the Commission was to come up with the best possible answer under the circumstances, and I congratulate you for accomplishing that goal. In this letter, I wish to comment only on some salient points--where we did a good job and also where more needs to be done. (A more detailed description of my views is contained in the enclosed report.) Naturally, in an exercise such as we have gone through, not everyone is satisfied. Indeed, compromise has been defined as a solution in which nobody is totally happy!

We began with the imperative that we had to solve the insurance coverage problem for the people not covered. This group is growing both in numbers and as a percentage of the population and is likely to continue to do so unless some policy changes are made. Indeed, the current system of insurance coverage is making it less and less economically feasible for an increasing number of small businesses. The result is that coverage is being dropped or scaled back dramatically. Especially punished in this process are the children of America. The fact that so many children are uninsured cries out for a solution, as does the need for prenatal care. We must have healthy children if we are going to tackle the problem of education, unemployment, crime, drugs and other societal ills which cannot be solved unless the young people entering our society and our economic system have good health. It makes good economic sense: we can either pay up front or pay more later--much more. The cost is not just in health care but for all sorts of societal ills that grow out of these fundamental problems.

A number of our Commission members hoped, as I did, to use the occasion of The Pepper Commission to institute some fundamental reforms of health care in this country. On the one end of that spectrum are those who hoped to create a single-payor government run health insurance program in order to "get it all over with right now." On the other end are those who wish to overturn the present system and to introduce a free market, free choice system. It became apparent to me, and I believe to the Commission as a whole, that neither approach is feasible at the present time. On a practical level, we simply cannot get there from here.

THREE MELLON BANK CENTER
PHILADELPHIA, PA 19102
TELEPHONES: 215 963 3500 212 687 8300

Hence, The Pepper Commission arrived at a pragmatic solution: building upon a job-based public system. I recognize that ultimately requiring employers to provide coverage, even with the protection our recommendations include, is a rather new idea in employer/employee relations, but I think the country is ready for it, and the pragmatic solution to the access problem is in that direction.

Requiring employers to provide coverage puts a burden on all employers,and especially on small business. I start with the premise that small businessmen want to be full-fledged members of the business community and pay their full share of the cost of doing business. Over time, the small employer will become less and less able to compete for a quality, stable workforce without providing health insurance benefits. The Pepper Commission's plan provides extensive opportunities for voluntary coverage by small businesses with appropriate periods of adjustment and federally subsidized phase-ins. The availability of a public plan that employers can buy into makes coverage eminently affordable for small businesses. Unquestionably, The Pepper Commission plan presents a major challenge for small business. Yet, if the premise is correct (that small businessmen want to become full-fledged members of the business community), this plan makes that possible.

As you know from our deliberations, some of my major concerns were in the area of cost containment. We made some important steps in this direction, but more need to be made. I find it economically baffling and unacceptable that we are spending more on health care, both absolutely and as a percentage of GNP, than any country in the world, and we still have a system that is not accessible for so many and imposes such financial burdens on those that have individual plans. We can't afford not to change our health care access and delivery system but to do so will require us to confront, with some semblance of logic and plain common sense, the task of controlling costs. To begin with, we need to confront issues that have been avoided in the public arena. We need to ask some tough questions, such as:

- What kind of health care does society owe its less fortunate?
- How can we can control costs in a fee-for-service system where competition seemingly does not do the job and the alternative is an incredibly complex bureaucracy that increases wasteful administrative costs?
- When should care be limited or withdrawn?
- Is it logical to shift so many resources to sustaining the dying at the expense of not helping the living?
- Can we talk openly about spreading our limited health care resources across the spectrum of health care needs?
- Why should the tax code subsidize coverage for some, while millions of others are not covered?

These kinds of issues raise the bugaboo of rationing or of two-tier medicine. We have rationing now--some people are rationed right out of access to health care on economic grounds. Needless to say, those who lack coverage, or have limited coverage, are already suffering the ultimate in two-tier medicine by not having any at all. Unless we deal with these difficult issues our whole system will sink and damage our society and competitive position in the process.

I support the provisions in the plan that will control costs, such as provisions to: override the mandates of benefits that have crept into state laws and increased the cost of coverage; increased outcomes research--which will increase our knowledge of the balance between medical cost inputs and medical outcomes benefits; reform of the tax code to provide equity in the system and to encourage private sector participation; and to begin to address tort reform in the malpractice system.

In an ideal world, and if I were designing the plan myself, I would include many more measures to control costs. Practically every health care consumer knows health care costs increases are the real killer that can eventually strangle the system. Although the plan does not include everything that I would prefer, I support it. I believe that The Pepper Commission plan will shape the health care debate for many years to come It throws down the gauntlet of access to the health system so that all Americans can receive adequate health care. Any other approach will have to be measured against that standard. The need for action is urgent and compromise is necessary to get things moving. I believe that The Pepper Commission recommendations move us along that agenda and I would be more than happy to work with you and with others to enhance and refine the program. But most importantly, I look forward to continuing to work with you as you move these recommendations toward enactment. I would urge that the Congress immediately address the question of prenatal and child care. While many aspects of health care policy reforms can wait, any wait on these issues is both unconscionable and economically unwise.

I know from having observed you over these many months that you have the courage, wisdom and persistence to make things happen. And I was enormously impressed with the devotion and caring of all of the members of the Commission. It was an honor for me to have worked with them and with you.

With all good wishes and warmest regards,

JB:fl
Enc. (*Health Policy Papers*)

1838 INVESTMENT ADVISORS

HEALTH POLICY PAPERS

I. Are We Climbing the Wall of Resistance Toward National Health Insurance?

II. Developments in Health Care Policy: Report on the United States Bipartisan Commission on Comprehensive Health Care (The Pepper Commission)

by

James Balog

One Meridian Plaza
Philadelphia, PA 19102
215/963-3500
Fax: 215/557-8586

405 Lexington Avenue
Chrysler Bldg. - 42nd Floor
New York, NY 10174
212/687-8300
Fax: 212/286-0921

1838 Investment Advisors
Health Policy Papers

Preface

The issues surrounding health care policy are extremely important to the future of our country. We must deal with the problem of health care spending in order to maintain our competitive standing in the world. The United States is now spending a larger proportion of its GNP on health care than any other country. American business is now devoting 50 percent of its corporate operating profit to health care for its employees and retirees.

As if the sheer size of the overall health care problem and its rapid growth were not enough for American business, the accounting profession is considering instituting a further burden: reserves for unfunded liabilities. Estimates of these hidden liabilities range from $169 billion to $2 trillion dollars and could equal all other liabilities on the balance sheets of American corporations. The effect on American business would be devastating.

Reflecting our position as one of the foremost managers of assets for medical associations, malpractice insurance companies, hospitals, and pools of capital from other health industry participants, 1838 Investment Advisors has a long-standing interest in the health care field. James Balog, Chairman of 1838 Investment Advisors, has had a lifelong involvement in health care policy; over the past ten years at the federal level. Most recently he has been serving on the United States Bipartisan Commission on Comprehensive Health Care (The Pepper Commission). His observations on The Pepper Commission are contained in Part II of this booklet.

Part I, originally published by 1838 Investment Advisors last year, is the historical review of the development of health care policy in the United States leading up to The Pepper Commission.

We hope these papers are of interest and value to you and we welcome your comments.

James Balog is Chairman of 1838 Investment Advisors in Philadelphia. He has had a lifelong involvement with the U.S. health care industry, both as an industry analyst and as a policy expert. In 1981 Mr. Balog was Committee Chairman for the White House Conference on Aging. In 1983-84 he was a member of the Advisory Council on Medicare, also known as the Bowen Commission. In 1986-87 Mr. Balog was Chairman of the Private/Public Sector Advisory Committee on Catastrophic Illness. This Advisory Committee's work was reflected in the Medicare Catastrophic Coverage Act of 1988. In 1989, Mr. Balog was appointed by President Reagan to the United States Bipartisan Commission on Comprehensive Health Care (The Pepper Commission). His Wall Street experience spans the period 1961 to present, in activities ranging from analyst, portfolio manager, research director and chief investment officer. Prior to this, Mr. Balog was with Merck & Co. for ten years, starting as a research chemist and had subsequent experience in engineering, production, and finance. He graduated from Penn State (School of Chemistry and Physics) and received his MBA from Rutgers Graduate School of Business.

April 1990

ARE WE CLIMBING THE WALL OF RESISTANCE TOWARD NATIONAL HEALTH INSURANCE?

By: James Balog

Introduction

The Financial Accounting Standards Board wants the hidden liability of corporate health care expenditures brought into the open. The current proposal calls for accrual accounting on the profit and loss statement by 1992 and the recording of a "minimum" liability on balance sheets by 1997. Health benefit costs may be as important to American business as the economic integration of Europe in 1992 or the Chinese takeover of Hong Kong in 1997. How did the problem get so big and how might it be resolved?

History

The idea of government sponsored health care, retirement systems, and other social programs began in 1883 in Bismarck's Germany. The entry age was established at age 65, a sufficiently high level since life expectancy was then under fifty years. Not many people were expected to be able to take advantage of the national health insurance program. Since then, life expectancy has risen to 70-75 years of age in most of the developed world, and advances in medical technology have resulted in more ways to treat people and sustain life longer. All of this gain, however, comes at an ever increasing cost.

By now most countries have some form of national health insurance, universal health coverage or comprehensive medical care. The U.K. began its plan in 1948; Canada's policy evolved over 20 years to a complete plan by 1971. A National Health Insurance Plan was first proposed for the U.S. by President Truman in 1948. Instead we adopted the Medicare program in 1965, choosing to care only for those persons reaching the Bismarckian age standard.

In all countries of the world, the specter of crushing cost burdens haunts policymakers. Faced with overwhelming demand for services, public and private health care administrators are feverishly attempting to control costs while still providing decent and affordable care. A common denominator of universal plans is pay-as-you-go financing through general revenues derived from broad-based taxes on wages. Cost control attempts include provisions such as:

- **Co-payments:** For all or most services the patient pays something.
- **Deductibles:** Plan coverage begins only after the patient has incurred some minimum of personal cost each year.
- **Spending Caps:** Governments pay only a certain amount per patient in each time period.
- **Regulated Provider Fees:** Hospital and physician fees are preset and increases regulated.
- **Queuing:** Usually as a consequence of other cost control techniques (but perhaps by design) medical services are rationed by assigning priorities for type of procedure, patient's age or other criteria.

Comparative Statistics

A comparison of health care spending in five major developed countries reveals that the U.S. has the highest spending as a percentage of GNP and per capita. But the most startling fact is that the U.S. is unique in having such a small percentage funded by the government (Table 1).

Table 1

Summary of Health Care Expenditures

	Percent of Gross National Product	Per Capita Expenditures*	Percent Government Funded
United Kingdom	6.5%	$ 715	90%
West Germany	8.0%	1,031	80
France	9.5%	1,039	80
Sweden	9.0%	1,195	90
United States	11.0%	1,926	40

*Adjusted for purchasing power parity with the U.S. dollar

There are big differences among countries in the level of satisfaction with the system. A recent survey asked approximately 1,000 to 1,250 consumers in each of three countries how satisfied they were with the medical care system (Table 2). In spite of the high per capita cost and the high percentage of GNP devoted to health care, Americans are the least happy with the system, though there is a significant degree of unhappiness in the U.K. and Canada. Canadians seem to like their health care system the best, but that may merely be a function of the fact that they have had their system about half as long as the British. It may be that any system breeds dissatisfaction because of the inevitable need to constrain spending and ration services.

Table 2

Level of Satisfaction With Health Care Delivery Systems

	System Needs Fundamental Change	Satisfaction With Doctor Visit
United States	89%	54%
United Kingdom	69	63
Canada	42	73

Canada has begun its system without co-payments or deductibles, the absence of which can contribute to excessive spending. Instead, Canada has relied upon capping total costs at the federal level and rationing services. In all probability, dissatisfaction will rise with time. Yet there seems to be an attraction for Americans with the idea of a Canadian system--universal coverage funded by general taxation. Sixty-one percent of Americans would prefer the Canadian system, whereas only 3 percent of Canadians and only 12 percent of the British would want the American system.

In many other ways there are significant differences in health care patterns among countries. The average Frenchman gets 28 prescriptions per year; the average Englishman and American get 7 prescriptions per year. In Germany, prescription drugs take up 15 percent of health care spending, twice that of most other nations. This is generally attributed to the fact that the German drug industry is very powerful and able to maintain prices on its home turf. American costs are significantly impacted by malpractice claims, probably 10 times the incidence in Canada. In Canada, verdicts are not by jury but by judges only, and the losing plaintiff pays legal costs if the doctor or hospital is found innocent.

Administrative costs differ among countries. In France the administration of the health care system employs 250,000 people and devours 8 percent of total health care spending compared with about 3 percent for the U.S. Medicare system and 3 percent for the Canadian system.

The U.S. Experience

In the U.S. the Medicare Act was passed in 1965 as part of President Johnson's Great Society program. Seemingly, in every year since 1965, leaders across the political spectrum have been advocating a full national health insurance program to extend coverage to all persons. In fact, the bulk of government expenditures have taken place for the Medicare population, persons aged 65 years or above, and some extensions of coverage have been made for the disabled and poor.

In 1965, health care spending in the U.S. was $52 billion or 5.9 percent of GNP. By 1987, health care spending rose to $550 billion or 11.1 percent of GNP. The rate of increase has not slowed and in fact, may be accelerating. The 1986-87 period was particularly unnerving for many corporate plans, with annual increases of 30 percent quite common. One reason for this major increase is that Medicare's Diagnosis Related Group (DRG) system has limited hospital payments by the Medicare program, shifting costs onto private plans.

Over the past 20 years there has been a continual and significant shift in health care spending away from individuals toward private insurance and public programs (Table 3).

Table 3

Percent Change in Spending on Health Care Delivery Systems

Payor	1967	1987
Patient	43%	30%
Private Plans	22	30
Government	34	40

The Medicare Dilemma

The Medicare plan was adopted over the forecasts of an impending apocalypse by organized medicine and fiscal experts--one group fearing socialized medicine and the other runaway costs. To a greater or lesser degree, both have been right. The Medicare system was based on "fee for service" so that doctors would feel little change in their relationships with a patient and could charge their normal and customary fee. They would remain the gatekeeper for access to the hospital. Hospitals became the primary point for delivery of medical care. Why? Policymakers were fearful that if medical services were delivered in an outpatient or home setting, control of usage would be very difficult and costs would climb out of control. With a doctor as the gatekeeper and the hospital as the venue it was felt that costs could be limited. The result of these two concerns--a "non-socialized" system and a hospital-based delivery system--is an expensive system. For care to be covered, it must be delivered in a hospital setting. Hospitals are not "care" facilities, they are "cure" facilities. Many of the elderly need care not cure, yet the system keeps them in an expensive hospital even though outpatient treatment might be more cost- and medically-effective. Overall, few changes were made in the delivery system--Medicare pumped more demand into a cost-plus fee-for-service system.

Part A of Medicare covers hospital stays. It is totally financed by payroll taxes assessed on the working population to pay for those 65 and older regardless of whether or not the beneficiaries are working and whether or not they are medically indigent. Usage is controlled by deductibles and co-payments. Most notably, the first day's hospital stay is paid for by the patient.

Part B of Medicare covers doctor bills. It was originally designed for 50-50 payment, half by general revenues and half by beneficiaries. As costs escalated, it became politically undesirable to raise the Part B premiums. The beneficiary proportion dropped to 25 percent and general revenues picked up about three-quarters. In the Reagan years, an unsuccessful attempt was made to restore the 50-50 split. The primary method for cost control is the use of co-payments. Basically, the patient pays 20 percent of the normal and customary doctor's fee set by Medicare. Significantly, doctors' fees set by Medicare have been limited to an economic index since 1972 and rates of increase for some years were frozen entirely. As a result, the patient often pays much more than 20 percent of the doctor's bill since the doctors are billing more than the Medicare allowable.

The next step in Medicare coverage, the Medicare Catastrophic Coverage Act of 1988, had an entirely different basis. The most fundamental difference is that catastrophic coverage is an *insurance* program paid for entirely by the covered population and does not involve any outside funding from payroll taxes or general revenue. Moreover, it is a mandatory insurance program--every participant in Medicare must belong to the insurance program. Another significant departure is that not all members of the insurance program pay the same amount. All participants pay $4 per month, per person. But there is an income tax surcharge of 15 percent levied on those who pay taxes and therefore have income. The cap is $800 per person, per year. Thus, those who have more, pay more--a vastly different concept than is true in the rest of the Medicare program. But, even with this income tax surcharge, there is still an overall subsidy of some $700 per year across all parts of Medicare, even for those persons who pay the maximum surcharge.

Another feature of the Catastrophic Coverage Act is that it will for the first time pay for drugs, beginning in 1992. There is a very high deductible of $600 above which the catastrophic coverage will pay for drugs. In Medicare Parts A and B drugs are not covered, except those given in a hospital stay, a legacy of the fear of runaway costs.

The catastrophic plan is not even a year old and may not live to an old age[1]; already there are disputes over whether or not the funding is excessive, too low, or unfair. The political heat has gotten very high because of the income tax surcharge. Yet there are others whose calculations purport to show that the drug component of catastrophic coverage is headed for bankruptcy even before it starts. President Bush recently indicated he would not advocate a change in the terms of the bill to reduce premiums; the Chairman of the House Ways and Means Committee has endorsed that position. This is probably a wise course of action since estimates of health care spending have been notoriously off the mark. For instance, when the Medicare bill was passed, expenditures in 1990 were expected to be $10 billion. The current estimate for 1990 is $110 billion.

The Medicare system has two major flaws. First, it does not take care of those who are unable to make required payments, either co-payments or deductibles. In order to provide a safety net for poor persons, the Medicaid program operates at the state level. Medicaid costs in America now run at $46 billion, but Medicaid suffers from highly variable coverage from state to state and requires spenddown. Spenddown means that in order to take advantage of the Medicaid safety net one must have assets no greater than $2,000 per person and $3,000 per couple. Many older people are reluctant to become financially destitute in order to pay for needed health care services. The system also encourages asset shifting by the elderly to their dependents in order to meet spenddown requirements.

The second major flaw is that the current system is not designed for long-term care. The "Medicure" system has inadequate mechanisms for providing the type of care required by many elderly people, especially those over 75. Moreover, the lack of "care" facilities means that costly cure facilities are overburdened with persons who can be cared for more economically in facilities other than hospitals.

The Long-Term Care Issue

Long-term care was not included in the Catastrophic Coverage Act largely because the costs were unknown but believed to be astronomical. There has been limited actuarial experience by private insurance carriers for the concept of long-term care. In addition, there was a feeling that Medicaid provided a safety net for those in need of long-term care, albeit with the onus of the spenddown provision. But the push is on for long-term care coverage and one of the principal mandated objectives of the Bipartisan Commission is to make recommendations to Congress for long-term care coverage. The estimated cost for long-term care in the first year is $45 billion (compared with 1988 spending for Medicare of $78.9 billion). This $45 billion is not all incremental health care spending; it is estimated that long-term care provided by private plans, Medicaid, and private spending now consumes about $11 billion. Nonetheless, long-term care is a major economic commitment.

Comprehensive Health Care

Another major issue for the future is to cover millions of people not now covered by Medicare or by private plans. The frequently quoted figures are in the 31-37 million range though there are some statistical problems. For one, about one-fifth of the total represents people who are "not covered" because they chose to be covered under a spousal plan. For another, about 10 percent of "employed but not covered" have not yet completed eligibility requirements. Typically, Americans are reasonably well off, medically speaking, if they are 65 or older or are employed by a major corporation. Virtually 100 percent of all firms with 500 or more employees provide coverage, but only 46 percent of those with 1-9 employees and 78 percent with 10-24 employees. Younger people who are unemployed or self-employed and people employed by small businesses have the greatest problem accessing medical care for economic reasons (Table 4).

---

[1] Editor's note: At press time each House of Congress had voted to rescind the Medicare Catastrophic Coverage Act and the two versions of the recision are being reconciled as to the remnants that will remain in the Law

Table 4

Age Distribution of Population Without Health Insurance (1987)

Age	%
Under 18	27
18-24	20
25-34	23
35-64	29
65 and over	1
Total	100%

A strong drive is being made currently to do something about this problem. Complicating the solution and the cost estimates is the fact that most AIDS patients fall into this category. The health care cost for an AIDS patient is about $100,000 per year and a typical AIDS patient is treated for approximately 18 to 24 months. This represents around $15-20 billion to treat all current AIDS victims. The current therapies for AIDS merely prolong life--and medical costs--for varying amounts of time but the disease remains fatal. In major cities such as New York, the AIDS problem is already paralyzing the health care delivery system. The utilization of health care resources is one problem and the other is that there is no adequate way for the hospitals and doctors to be compensated for services. The likelihood is for additional major cost shifting to private plans.

The Unfunded Liability Problem

As if the sheer size of the overall health care problem and its rapid growth were not enough for American business, the accounting profession is now considering instituting a further burden: reserves for unfunded liabilities. That is, a corporation has an obligation, stated or implied, to provide health care coverage for its employees and its retired employees. Good accounting standards require companies to recognize this future cost by charging it to the profit and loss statement each year and building up an adequate reserve to pay for it. The effect on American business would be devastating. The Employee Benefit Research Institute has estimated, conservatively, that the present value of the liability for all private employers is $169 billion (1988). Other estimates run as high as $2 trillion, not far below *all* the liabilities non-financial corporations carry on their books.

How Did We Get Into This Mess

The U.S. health care system now finds itself in the financial intensive care unit because it did not follow the standards of that other great employee benefit, the pension system. The private pension system:

- Assumes a defined liability, a certain contribution or a specified dollar amount of benefit.
- Is based on actuarial assumptions of life spans.
- Covers the employee and often the spouse, not other family members.
- Does not carry the inflation risk; the beneficiary does.

In addition, reserves were established and contributions to the fund are tax deductible when made.

Health benefits are largely *undefined.* Because the cost of the benefit was not expected to be large, most companies did it on a pay-as-you-go basis without a reserve buildup. Contributions to the pension fund are deductible in the year in which the contribution is made--contributions to a health care trust fund are not tax deductible, so most companies do not have a trust fund for future liabilities of retirees and current employees, another reason to fund them on a pay-as-you-go basis. Moreover, unlike pension plans, many health plans cover dependents of workers and of retirees. And, finally, the specter of inflation is aggravating the problem because costs for medical care are increasing at 2 to 3 times the inflation rate. The employer usually assumes the burden of health care at any cost.

Forecasts

Forecasts are hazardous in any field, but especially so in health care policy. The progress of policy is heavily intertwined with social and economic trends. Our country is now running huge fiscal deficits and there *is* no general revenue to share without more general taxes. Until the Tax Act of 1984 we had a silent, politically easy way to raise taxes: bracket creep. As inflation drove nominal wages higher and higher, taxpayers went into higher and higher brackets. The government collected more taxes without having to legislate a tax increase. Wage earners saw their after-tax purchasing power decline. Bracket creep was eliminated when income tax brackets were indexed to inflation. Any increases to pay for the cost of government now require politically risky tax increases.

Congress has discovered a substitute for bracket creep: mandated benefits. This is the simple expedient of having Congress or state legislatures pass laws to require corporations and insurers to provide certain benefits which they then must put into their cost and price structure. This, of course, has economic implications for U.S. competitiveness that will manifest themselves only in the long run. The short run is more relevant. My guess is that Congress will attempt to mandate that long-term care benefits be incorporated into private plans. This will add to unfunded liabilities and force a solution to the unfunded liability problem. Then what?

The Global Solution

I have observed over years of watching public policy being made that one must look for a confluence of events which ultimately pushes policy over the wall of resistance. The weakening of resistance combines with continued pressure for change. Here is how the constituencies are lining up on the universal health insurance debate:

- Many Americans are dissatisfied with their public or private health care plan (or their lack of one) and want something better.

- Business is faced with an enormous unfunded liability problem and will welcome a global solution. Certainly small business would be reluctant to pick up a share of the 31-37 million uncovered persons.

- Hospitals are going bankrupt at an alarming rate (about one per week in this decade) and are ready for a different funding mechanism.

- The doctors are feeling the hobnails of the bureaucratic boot and are getting more and more frustrated with how to deliver the quality care while dealing with fiscal restraints. The National Medical Association has already endorsed a national health insurance program. It is a long way from the NMA to the AMA but the frustration level is rising, even among doctors. In an editorial in July 1986, the *New England Journal of Medicine* noted, "Perhaps even the medical profession, disenchanted with the private corporations and the competitive market will some day be leading the campaign for a publicly financed alternative."

- The bureaucracy is ready.

Conclusions

It remains to be seen how much of a dent the United States Bipartisan Commission on Comprehensive Health Care will make in solving this massive problem. Perhaps, more correctly, not a dent in solving the problem but rather the extent to which it will make a *beginning* toward a comprehensive solution of a comprehensive problem. For the longer term, will the larger solution continue to involve the private sector or will it become a national health insurance program? If we do not solve it with a major new private sector involvement, I predict by the year 2000 all the constituencies will unite to climb the wall of resistance to a comprehensive health care program funded from general taxation.

June 1989

DEVELOPMENTS IN HEALTH CARE POLICY: REPORT ON THE UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE (THE PEPPER COMMISSION)

By: James Balog

Introduction

In this report I will present a highly personalized view of the deliberations and findings of the United States Bipartisan Commission on Comprehensive Health Care (The Pepper Commission). Even though I have been involved in health care policy matters at the federal level for over ten years, it is still an "outsider's" view because the central thrust of this Commission was political. It provided me an interesting and instructive insight into the legislative forces and interest groups which shape health care policy in this country. As I look back over the ten years that I have been at health care policy discussions at the federal level, I am reminded of what Satchel Paige once said, "Don't look back, it may be gaining on you." The health care problem *is* gaining on us. The longer I am at it, the more I realize that the problem is growing at a faster rate than my understanding of it and faster than the ability of Congress to deal with it.

Harkening back to an earlier career in pharmaceutical research, I came up with two ways to solve the health care problem in America: the natural, easy way and the miraculous, hard way.

The **Natural Way** fantasy I came up with is to have a divinely inspired biotechnologist, guided directly by the hand of God, invent a pill that gives everybody a disease-free life from birth to death. Life span would be randomly established at birth by a supercomputer.

The **Miraculous Way** is for the federal government to do it.

I am going to try to transport you to that **miraculous** island surrounded by reality called Washington, D.C. I will discuss:

- The origin of The Pepper Commission
- The workings of it
- The systemic reforms the Commission touched on
- Cost control measures
- Funding

And most important to you:

- **Why** things went as they did because this will give you the greatest insight into what to expect in legislation over time.

- **What** I think will happen and **when**.

These are my interpretations and are certainly not a consensus of members' views.

The Origin of The United States Bipartisan Commission on Comprehensive Health Care (The Pepper Commission)

In all of the debate on the Catastrophic Health Care Act, which was signed into law July 1988, it was clear that the older Americans wanted long-term care coverage. In fact, many of them thought they got long-term care coverage with the Catastrophic Health Care Act and that misconception contributed heavily to its demise. The Catastrophic Health Care Act did take some very important steps toward assuaging the fears of the elderly Americans concerning financial ruin from catastrophic illness though it certainly was a far cry from long-term care. In addition to the misunderstanding of the benefit package, the Achilles' heel of the whole legislation was that it required the beneficiaries of the plan to pay for it. The original catastrophic health insurance benefit plan advanced by Secretary Bowen would have extended Medicare benefits to include many of the elderly's uncovered medical care costs. This had overwhelming popular support, over

89%, among all segments of our society. However, after the legislation was implemented, it became more widely recognized that the bulk of the additional costs of this program would be paid for by a new surcharge on income tax of middle- and upper-income elderly. In a way, it carried the dreaded virus of means testing--the more you have, the more you pay. The sentiment shifted and the plan was roundly denounced by all those familiar with it, especially the elderly, and most savagely by those in upper income brackets who were most likely to pay the new surcharge and get the least benefits--not a surprising turn of events.

To get the support of Senator Pepper and other legislators who wanted long-term care coverage, the bill included a proviso that a bipartisan commission would be formed in order to make recommendations to Congress within a year for legislation to provide long-term care. Others were concerned about the fact that over 31 million Americans lack health insurance and another 20 million are underinsured. A section in the Catastrophic Health Care Act created a Bipartisan Commission, made up of six Senators, six Congressmen, all heavyweights in committees concerned with health, aging or finance, and three Presidential appointees, and charged it with responsibility to make specific legislative and funding recommendations within a year from the signing of the Act; that is, by July 1989. There were many delays in getting the Commission organized and in fact I did not get my appointment confirmed until the early part of January 1989 and the Commission did not meet until February 1989. In one of our first meetings, Senator Pepper undertook the extension of the deadline of the Commission to November 1989. By then Senator Pepper was quite ill and upon his death, Senator Jay Rockefeller (West Virginia) took over the Chairmanship and one of his first acts was to extend the deadline to March 1, 1990. We then turned our attention to three issues: Access, Long-Term Care and How to Pay For It.

The Question of Access

Most members seem to feel that the first priority for any new resources in the health care field should go toward providing coverage for some 31-37 million Americans who are not now covered by health insurance. This group of people is rising both in number and as a percentage of the total population. The priority for access derives from the general feeling that it is scandalous that the United States' spending, fast approaching 12% of GNP, is the highest in the world, its medical care the best in the world, and yet 15% of the population does not have health insurance coverage and ready access to the medical care system.

Within this 15%, the members focused especially on children (some 8 million) and pregnant women. It is generally agreed that most preventive care is both good medical and economic policy. Virtually all would agree that the most effective preventive care is for young children and pregnant women. Perhaps 80% of the time of the Commission was spent on access, reflecting its high priority and the markedly different approaches vigorously championed by members--reformers and non-reformers.

The Reformers

One major policy debate on access revolved around whether or not there should be systemic reform of the whole health care system. Some would reform the current system which covers 85% of the people through job-related plans or Medicare in order to get a "better system" to cover the remaining 15%. They believe that we should introduce an entirely new way of financing health care (including Medicare) through use of vouchers. The idea is to introduce free market principles into the health care equation in order to ultimately stimulate free choice and control costs. Other reformers, albeit the antithesis of free market philosophers, are those who want to go all the way, now, to a National Health Insurance System.

A National Health Insurance System along the lines of Canada's was discussed many times and hovered over the deliberations, especially in the beginning. This was a program favored by many Washington "old hands" in health care. But it seemed that many of the members concluded that we couldn't get there from here; there are too many cultural differences, funding differences, lack of confidence in federal programs, differences in the legislative systems, etc., etc. which prevented us from seriously going down the Canadian path. There was also a feeling that the Canadian system is increasingly featuring cost containment through rationing and is going down the path of the British National Health Service. The early enthusiasm for a Canadian approach gave way to a skepticism. Whether pursuit of a Canadian system will resurface in Congress is hard to say, but it is certainly possible.

The Non-Reformers

At the other end of the spectrum are the non-reformers--those who believe that the bulk of the present system for non-elderly is job-based and that the remaining 15% should be covered on the job. It's a popular approach. According to an Employee Benefits Research Institute survey, 80% of Americans favor mandated benefits. One way has great budgetary appeal: a plain, unsubsidized mandate that all businesses must cover employees and all self-employed persons must buy coverage. The other less onerous method is a subsidized job-based system to bring everybody under an employer plan with special subsidies to ease the pain for small business. The concerns about small business are very widespread and very real. Members recognize the importance of small business to job formation in this country and recognize that any kind of a plan is likely to have a cost equivalent of at least 25¢ per hour. This would put an extra burden on small business at least as bad as the minimum wage increases that were recently enacted after much debate and apocalyptic economic commentary.

In spite of problems--and the myriad of rules and subsidies it would entail--the bulk of the deliberation was devoted to a job-based system, with as much volunteerism, seduction, and, finally, coercion as necessary to cover most of the 15% of employees now without insurance coverage. The federal government picks up the unemployed and, especially, subsidizes child and prenatal care.

The job-based system has the following key attributes:

1) Benefits are roughly a Medicare package.

2) It rolls much of Medicaid into the Medicare system, a major federalization.

3) It will be subsidized and phased in for small business in order to ease the economic pain. The subsidy period will be available only for the five years after enactment of the law.

4) It is likely to especially subsidize, maybe on a permanent basis, coverage for children and prenatal care.

5) Major reforms of the insurance market.

6) The federal cost is estimated at $23 billion per year when fully phased in over five years.

A word about estimates is appropriate. Estimates of health care costs, especially of government programs are notoriously bad, usually low. For example, 1990 Medicare costs are ten times the original estimates. The Pepper Commission cost estimates have already been challenged as far too low. Yet, someone must reach into the big, dark future and take a guess.

As for me, I am like the little boy in the dark: **I am not afraid of the dark, but I am afraid of what's hiding in the dark.**

Long-Term Care

Long-term care discussions were much less complicated and less contentious than one might have thought. The costs, the potential costs and inability to estimate them are horrendous worries and one would have thought this would cause a great deal of debate. As it turned out, the controversies were largely over front-end vs. back-end coverage and the extent of the benefit package. Seemingly, few legislators want to be against long-term care because of the power of the gray lobby. The real problem here will be one of financing and the benefit package itself is expensive no matter how you go about it.

The key elements:

1) A social insurance type of program (no means testing) for nursing home care for the severely disabled, elderly and non-elderly; three months, with a 20% co-pay, for skilled and custodial care.

2) There is a major initiative toward home care; three months' coverage, both for the elderly and the non-elderly, regardless of economic status.

3) The current spenddown requirements of Medicaid are considerably liberalized, up from $2,000 per person to $30,000. There is also a significant liberalization of personal care and housing needs allowance both for the patient and the spouse.

4) States administer the plan, the funding is largely federal with some state support.

5) The states' role is large because home care and nursing home care were considered better administered by states.

6) There are some incentives for development of private nursing home insurance.

As you can imagine, the costs of this program would be tremendous; the home care benefit is estimated to cost somewhere in the area of $24 billion per year when fully phased in after four years. This figure is very soft because no one has any idea how much informal care now being provided would immediately shift over to coverage. This is especially true for the non-elderly persons who would receive home care. For the expanded nursing home care package with a three-month front-end the estimated cost is at least $19 billion annually when fully phased in. Now perhaps it becomes clear why the discussion of long-term care was so muted; the numbers themselves numb the brain.

Cost Containment

This whole area of cost containment reared its head from time to time but was never fully addressed. The polarity on it was somewhat like this:

On one end were those who feel that any major cost containment measures would individually be a "killer amendment" or that smaller measures would add up to a "killer amendment." A killer amendment, of course, is a provision that would gore the ox of some powerful interest group sufficient to impair acceptance of the entire plan. Cost containment measures were subordinated, quickly, to the goal of getting a "grand design" that might be acceptable to enough constituencies. Such things as limiting physicians' reimbursement rates or compensation appeared on the Commission's screen for nano-seconds and disappeared from sight.

On the other end were those who feel that without major cost containment measures any proposals for expansion of access to coverage would not pass the "laugh test." The public and practically every health care consumer knows health care cost increases are the real killer that could eventually strangle the system. Lack of credible cost containment proposals could bring into question the credibility of the whole Pepper Commission effort.

Cost Containment Challenges

But beyond these purely political aspects of "killer amendments" and "laugh tests" is the basic question of the long-term viability of our present health care system. Health care already consumes almost 12% of GNP and is well on its way to 15% by the year 2000. We can't afford what we are now doing in global competitive terms--our percent of GNP is already 50% higher than many of our biggest trading partners, and double Japan's.

We can't afford not to change our health care access and delivery system. But to do so will require us to confront, with some semblance of logic and plain common sense, what we now do. Our present system is a leaky boat into which we want to put more people, sinking the present beneficiaries, any new ones we put in and damaging our competitive position in the process.

We need to confront some or all of the following issues; all of them no-no's in public policy arenas:

What does society owe its less fortunate?

Compassionate people would agree we owe the elderly and other needy persons food, shelter, clothing and health care. When we say food we don't say gourmet, we say nutritious. Shelter is not Trump Tower, its comfortable. And clothing is not St. Laurent, it's adequate. But when it comes to medical care, there are no modifiers, no limits.

Can good policy surmount the "every and always" syndrome?

All too frequently, policy suggestions are subjected to the concern that "not everybody will be covered" or that "it won't work under these rare circumstances." The result is a set of rules to be sure no one ever falls through the cracks and a program that is complicated and subject to "gaming" abuse. It would be better to implement a program that covers most of the people most of the time and provide a safety net mechanism to catch the exceptions.

How to control costs in a fee-for-service system?

Health care costs are a result of unit price times volume, of course, and can be controlled by controlling either one or both. But there are some unique economic behavioral features in health care:

1) Cut fees and volume goes up.

2) Cut utilization and unit costs go up.

3) Reduced demand often causes prices to go up, not down.

In short, the medical care economy does not act in a free market fashion. Since the "invisible hand" of competition does not seem to do the job, the result is an incredibly complex bureaucracy to deal with a system featuring multi-payer, fee-for-service and cost shifting.

Administrative costs are the second fastest growing component of health care costs (professional fees are first) and now account for upwards of 9% ($55 billion) of costs, not counting what is spent in providers' offices. Administrative complexity is diverting human and material resources that could be put to better use in delivering health care and is threatening to smother the system.

When should care be limited or withdrawn?

Our medical system pumps untold millions into heroic medical measures far exceeding the limits of rational care. The system provides care which goes from the rational, to the heroic, to the futile, and on to the senseless and even cruel. In the search for quantity of life, quality of life is forgotten. After all, the object of medicine is supposed to be a healthy life, not immortality.

Is it logical to shift so many resources to sustaining the dying at the expense of not helping the living?

On one end of the age spectrum, we pour in resources for the elderly while denying pre-natal care and adequate care for children. About one-third of all Medicare expenditures are made in the last year of life--and almost one-third of that in the last month. The extension of life and the low quality of life in those terminal days must be balanced against other health care needs. An interesting development occurred in March, 1990 when a hospital was sued by a man whose life was extended through heroic measures against his wishes and his doctor's instructions--the first wrongful life suit in history.

Can we talk openly about rationing care?

Health care is rationed everywhere, in one way or another. As the head of the U.K. health scheme had already concluded in the early 1950s, there is no limit to mankind's demand for "free" health care. In the U.S. it's often done by ability to pay, in nationalized schemes, by queuing (as in the U.K.) or practice guidelines. Let's do talk about it: let's rationalize rationing to intelligently spread our health care resources across the spectrum of needs.

Cost Containment Proposals

Among cost containment measures discussed by The Pepper Commission (a few of which will be in the formal report and others will be offered by members as comments) are:

1) **Tax caps** to limit the amount of insurance premiums that are deductible as a business expense by employers or exempt from wage income taxes for the recipients. Removing tax deductibility of all premiums would raise $50 billion per year. A more modest proposal to limit deductibility to $250 per month for a family plan would raise $5 billion per year. The notion here is that the tax code should not support gold-plated benefit plans above a certain level. This would raise revenues but would also help restrain costs because it would remove the myth that benefits are free. This idea will not be in the formal report, it's a "killer amendment."

2) Some thought was given to **abolishing first-dollar coverage** in every plan, private or public, a pernicious feature that contributes to the overuse of medical facilities. The idea here is that the persons present at the time of the delivery of the health care are the provider and the patient; notably absent is anyone with a serious economic interest in the events taking place. By requiring a co-payment for every procedure the patient would become the "economic cop at the point of delivery." This idea is not in the formal report, same political reason.

3) **Reform of the tort system** was widely discussed. The idea is to prevent the direct cost effects in our litigious society which cause huge damage awards and increase the cost of malpractice insurance. Malpractice insurance premiums alone add 1% or $6 billion to health care costs. Litigation costs and defensive medicine add at least another 1.5% or $9 billion. Some estimates place the total cost of defensive medicine at $30 billion or more. In Canada, malpractice costs (adjusted for population) are about one-tenth those in the U.S. Malpractice reform illustrates how intertwined the health care system is with other behavioral and cultural mores; here are a few things Canada does:

   a) The plaintiff pays the legal costs of the doctor or hospital if the court rules in favor of the defendant.

   b) Punitive damage awards are either non-existent or severely limited.

   c) Lawyers do not get contingency fees--the one-third split of the award so common in the U.S.

   d) Technical matters are usually decided by the judge, not by a jury.

Obviously, legislating in this area would mean taking on the trial lawyer fraternity. This was left to the appropriate committees of Congress.

4) **State mandated benefits** such as chiropractic care, eyeglasses, hair transplants, etc., which have crept into state plans have caused enormous increases in the cost and availability of plans. The Pepper Commission recommendations would override state mandated benefits in the basic plan.

5) **Outcomes research** received some commentary and will be in the formal report. The notion here is that we have only the sketchiest knowledge of the balance between medical cost inputs and medical outcomes benefits. The experiences with DRGs and with relative value scales for compensating physicians were considered to be successes which should be followed up with similar long-term research on inputs and outputs to be used as guidance for physicians, both to guide therapy choices and to assist in malpractice defense. Clearly, this kind of research may also lead eventually to controls on intensity of the application of procedures. This kind of research would be done by the medical fraternity itself and would not be some economic, government-based study. One such study is being done on a joint basis by the Rand Corporation and the American Medical Association.

6) **Reforming the tax code** to provide equity in the system and to encourage private sector participation, for example:

   a) Allow the self-employed individual the same deduction currently available to corporations. Currently, a self-employed individual is allowed only a 25% reduction in medical insurance premiums against this income.

b) Allow the conversion of the cash value of life insurance policies into long-term care coverage without the incidence of tax at the time of conversion.

Revenues

There was so little consensus on how this program would be paid for that the Chairman decided not to attempt definitive recommendations. The one modest attempt to reach a consensus was notably unsuccessful. Of the many ideas put forth, the highest vote-getting idea received only four votes. What the report says is:

A) Although some of the revenues necessary to support the above recommendations could come from savings achieved elsewhere in the federal budget, the Commission is committed to raising whatever additional revenues are necessary.

B) In considering what revenue options to adopt, the Commission recommends that the choice be guided by the following three criteria:

1. The final tax package ought to be progressive, requiring a higher contribution from those most able to bear increased tax burdens. That is, families with higher incomes would be asked to contribute a greater share of their incomes than required of lower income families.

2. Since persons of all ages would benefit, persons of all ages should contribute to financing the recommendations.

3. Revenues chosen should grow fast enough to keep up with benefit growth so that new sources of revenue will not need to be enacted over time. Rates of growth would need to be in excess of 8% to 9% per year.

C) Various combinations of revenue sources may be used that together meet these criteria even if individual tax sources may fall short in one category.

Prospects for Pepper Commission Recommendations

The conventional wisdom inside the Beltway is that The Pepper Commission recommendations are dead on arrival. My guess is they will have far greater life outside the Beltway and will help to shape the debate over coming years. I do agree that no wholesale writing of legislation along The Pepper Commission lines is likely, or, even less likely, has a serious chance for passage in this Congress (or even the next)..

Much more likely is that we are entering a decade of: (1) legislated incrementalism (2) mandates in various guises and (3) broad scale debate over basic reform.

Among the incremental steps, I see the following that could happen, in somewhat this order:

1) Child care - maybe school-based clinics to tie-in to the "education Presidency."

2) Prenatal care - probably the most cost-effective preventive care dollars we can spend.

3) Medicaid improvements - to update this program in terms of quality of care and of actual coverage (now only 40% of poor).

4) Any program is likely to preempt state laws which add 10-20% to cost because of inclusion of such things as hair transplants (Minnesota), acupuncture (three states), naturopathic medicine (2 states), chiropractic (36 states).

5) Improve Medigap insurance.

6) Home care benefits for Medicare - geriatric care often consists of hospitalization for acute flare-ups of chronic conditions; a more "seamless" system from hospital to home care makes sense. The care will be delivered in the best human and medical setting.

Concluding Remarks

How this all plays out is a very large question. When the Commission began its discussions, and when I began thinking about it, I felt that there was a reasonably good chance that the time was ripe for some major legislative initiatives. As we grappled with the problems it became clear just how complicated the issue really is from a political point of view--elections, lobbies, etc. This colors the discussion and affects the outcome of this Commission.

There are other initiatives underway. The Advisory Council on Social Security headed by Deborah Steelman will make recommendations after the turn of the year. There is another commission headed by Constance Horner at HHS. And finally, President Bush in his State of the Union message said that he would direct the Secretary of HHS to provide an overall review of the whole problem of health care coverage, cost and quality. I believe I can predict there will be a super-study commission spearheaded by the Administration through HHS, to review the findings of every other commission, including The Pepper Commission. It may be that this is the way that the synthesis of ideas can be brought out and the results of these commissions and a large number of other study groups can be synthesized into something that would get greater support. In any event, no recommendations will go very far without Administration leadership--this Administration or one that follows.

The American public is not widely enthusiastic about the need for national health insurance or wide expansion of the system. This topic has not been among the top five concerns of the American public in any poll in recent times even though eighty-nine percent of Americans believe the system needs fundamental reform. About two-thirds would like national health care--Canadian style. But, even those people who are interested in anything approaching national health insurance, are not interested in paying for it. People seem willing to pay $50 per year in extra taxes. Above $50 the support for NHI drops to under 30%. The incremental cost of The Pepper Commission recommendations, averaged over all the workforce would be more like $50 per month--National Health Insurance might be $150 per month.

Any initiative in any field must have a support ratio of at least 2 or 3 to 1 to get anywhere. The "environment" is one of the top five concerns of the American public and has that kind of support ratio; the resulting Clean Air legislation is a $22 billion per year **mandated** program, but it had the cache and administration support. The reality of Washington is that it is very difficult to get something positive through because legislators must overcome a coalition of negatives. It is very easy to get a large number of special interest groups to be against some small portion of every bill and such coalitions of negatives defeat the positive elements that might be in the bill. The Catastrophic Health Care Act is probably such an example because it had the support of the AARP; but the AARP, it turned out, did not have the support of that vocal group of its members who would pay the tax surtaxes. That group, perhaps 15% of the total universe of the elderly, helped defeat the bill. There were many other problems with that bill, but the coalition of negatives certainly brought it down to an ignominious defeat in one year's time.

There are plenty of reasons to be cynical about the process, though I am a hopeful cynic. But the health care problem will not go away, it is going to grow steadily and may well be a party platform plank in the next presidential election, perhaps even one supported by George Bush in his second run for the White House. If not this one, it could easily be in some subsequent election, when the presidential candidate makes it a key plank in his or her platform.

The Pepper Commission has been hailed and reviled as another compassionate/free-spending liberal program. But its focus on job-based access will keep it a prominent alternative in the public debate. It may not be the scheme that ultimately becomes the centerpiece of access but will at least stimulate intellectual energy from free market thinkers to come up with a well-thought-out alternative. ***For nothing so focuses the conservative mind as the fear we will all be hanged by a liberal idea become law.***

If the Pepper Commission causes the best minds in America to focus on the problem, it will have served a useful purpose.

April 1990

Additional Views of Senator Max Baucus

I am greatly honored to have had the opportunity to serve as Vice Chairman of the Pepper Commission. Working with such a tremendous group of health care experts has contributed to my understanding of the complexity of our system, and convinced me that it needs to be reformed. This report of the Pepper Commission, "A Call For Action," makes a solid step in that direction.

A few words of praise are in order. Jay Rockefeller has done an outstanding job of leading a diverse group of 15 people through a difficult area -- and guiding a majority to agreement. That is a great accomplishment.

I would also like to commend the Pepper Commission staff, who have worked many long days, weeks and months to produce a report on health care that is truly without equal.

And last but not least, I want to thank all of the people from my great state of Montana who shared with me the benefit of their knowledge and experience on health care and long-term care. It was Montanans -- of all ages and walks of life -- who have given me the personal side of this most personal issue.

* * *

This report of the Pepper Commission marks an important and long-awaited day for all Americans whose lives have been touched by the tragedy of long-term illness.

Many, many Americans are deeply concerned about long-term care. I learned about their concern most poignantly at a Pepper Commission hearing I held in my own state of Montana in June 1989. Hundreds of people attended and dozens testified at that five-hour hearing. Some told of their struggle to pay nursing home or home care bills for a disabled loved one. Others said they fear what would happen to them if they or a member of their family became seriously ill or disabled some day. They said they wouldn't be able to pay for it and the federal government doesn't do much to help.

That hearing convinced me of the need to find a way to relieve people of those fears and unbearable financial burdens. The Pepper Commission proposal on long-term care in this report accomplishes both. It lets people keep their dignity, their sanity, and their peace of mind. It protects people from having to give up everything they have in order to qualify for federal assistance. It recognizes that people of all ages and all income levels may need long-term care. Our proposal provides coverage for nursing home and home care. It also ensures a comfortable standard of living for people who must spend long periods of time in a nursing home, and greater protection for the income of their families. This proposal is an enormous improvement over the current situation where many people must "spend down" into poverty to qualify for Medicaid assistance.

The proposal makes good economic sense. Caring for a loved one with a long-term illness is a difficult and costly experience. The financial burden is just too much for all but the wealthiest people. The Pepper Commission's goal has been to help people who need long-term care. The proposal we agreed on meets that goal.

The access part of the Commission report deals with the need to provide adequate health insurance for the millions of people in this country who have none. This is an extremely important, and laudable, goal. And the Commission's proposal takes many positive steps that will help. But I cannot agree with the basic premise of the proposal: that all businesses must provide insurance for their employees. In fact, a large proportion of the people who lack health insurance work in small businesses. My own state of Montana is an overwhelmingly small-business state. I am convinced that small employers want to offer health insurance to their workers, but they just can't afford to. I support efforts to make health insurance more affordable, but not to shove it down the throats of the "mom and pop" businesses that are the backbone of my state, and the country. We need to help our small businesses expand and create new jobs. The proposed mandate would work in just the opposite way.

HOOVER INSTITUTION
ON WAR, REVOLUTION AND PEACE

Stanford, California 94305-6010

August 10, 1990

John D. Rockefeller IV
Chairman
The Pepper Commission
United States Bipartisan Commission on
Comprehensive Health Care
140 Cannon House Office Bldg.,
Washington, DC 20515

Dear Jay:

It was a privilege to have the opportunity to work with you and the other members of the Commission. I am truly sorry I was unable to vote for the plan you recommended.

Enclosed, for inclusion in the Commission's final report, are my views and recommendations.

I enjoyed working with you and hope that I will have the opportunity to work with you again in the future.

Yours sincerely,

John

John F. Cogan

JFC:j

AUGUST 1990 - PRELIMINARY DRAFT

VIEWS OF JOHN F. COGAN

U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE (THE PEPPER COMMISSION)

The Commission's failure to reach a strong consensus on its recommendations is deeply disappointing. The lack of affordable health insurance, the absence of an adequate long-term care insurance market, and the runaway costs of the current health care system have substantial social, economic, and human costs. The Pepper Commission provided an extraordinary opportunity to advance the public policy debate toward solutions to these problems. By failing to reach a consensus, we regrettably missed a unique opportunity.

Having voted against the majority's proposals, I want to express my views about these proposals and outline the direction I would suggest Congress take. Before addressing specifics, I wish to raise two basic concerns.

The majority's proposed solutions to the lack of affordable health insurance and long-term care both suffer from the same fundamental flaw--a failure to specify how they would be paid for. By its own estimate, the majority proposes to spend the extraordinary sum of $70 billion each year in federal government funds. No recommendation is offered as to where this money would come from. Instead, the majority provides only a well-worn laundry list of previously rejected tax options that has been circulating around Capitol Hill for a number of years. Given the present state of our federal finances, it is critical that any proposals for new programs be accompanied by a practicable plan to finance them. Ultimately, proposals that ignore the financing question will not be judged as responsible and will not be given serious attention.

Also, the central problem of the health care system today stems in large measure from its runaway costs. In the current environment, to propose layering a broad federal mandate and a new open-ended federal entitlement on the existing uncontrollable base of health care spending is fiscally unsound. To do so would exacerbate the upward spiralling costs, impair private sector productivity growth, and further impede the federal government's ability to finance other activities.

This does not necessarily mean that we must wait to improve access to health care or to provide some relief for the burden of long-term care until we have solved the cost control problem. However, prudence demands that our recognition of the state of the current health care environment temper the extravagance of any proposed expansions.

FLAWS IN COMMISSION'S HEALTH INSURANCE PROPOSAL

1. LOW-INCOME WORKERS WILL BEAR THE BRUNT OF THE COSTS

The majority's proposal that employers either provide all employees and their families with federally specified health insurance coverage or make contributions to a public health plan is a tax on workers. The burden of this tax will be borne in the form of lower wages and higher unemployment. Since most large employers with high-skilled labor already provide sufficient insurance to meet the federally mandated plan's specifications, the mandate will not affect them or their workers. When the plan is fully phased-in, the burden will fall primarily on low-skilled workers in small firms that currently do not provide health insurance because of its high cost. Because employers are also required to cover the families of their workers, low-income workers with families will be particularly hard hit. Ironically, these are precisely the workers the majority is most interested in helping. The fact that a job might be more valuable to the worker than the federal government's health plan doesn't matter. The freedom to choose is gone. The mandate is unequivocal.

The number of workers who would lose their jobs if the majority's plan were to become law is a matter of some speculation. However, recent estimates of labor demand suggest that a 10 percent increase in labor costs reduce employment by between 3 and 8 percent. The payroll tax required of employers who do not offer insurance, according to the Commission staff, is 7 percent and the number of workers in firms that currently do not provide health insurance is estimated to be about 25 million. Hence, it would not be unreasonable to expect that between 500,000 and 1.4 million workers would lose their jobs when the plan is fully phased-in. Although this job loss is a price that some may be willing to pay, I am not among them. A less costly alternative must be found.

2. FIRMS CURRENTLY PROVIDING OVERLY GENEROUS PLANS WILL BENEFIT:

As the Commission Report notes, the majority's plan is not self-financing. General taxpayer funds are required to subsidize the public health insurance plan. Beneficiaries of this subsidy include many large employers with overly generous health plans. Indeed, all corporations with health plans comparable to the public plan, but whose costs exceed the government specified payroll tax, will find it advantageous to dump their employees on to the public plan.

3. GENERAL TAXPAYER FUNDS WILL BE INCREASINGLY REQUIRED TO SUPPORT THE PUBLIC PLAN

The dynamics of the market and predictable legislative action guarantee that the amount of taxpayer contributions will grow over time. For the last 20 years, health care costs have risen more rapidly than wages. As this trend continues, the difference between the cost of employer-provided health care and the payroll tax will increase, providing even greater incentives for employers to dump their plan in favor of the public plan.

On top of this, government will invariably expand mandated benefits to cover ever-increasing numbers of procedures, providers, and services. Political muscle, as much as good health policy, will drive the increased coverage. This has been the experience at the state government level where the number of mandates has increased 50 percent in the last decade and now include such procedures as hair transplants, acupuncture, and in-vitro fertilization; and it further includes such providers as chiropractors, marriage counselors, and professional herb prescribers (naturopaths).

Also, the federal government has repeatedly demonstrated that it lacks the will to maintain adequate co-payments and deductibles to insure cost-conscious health care consumers. The Medicare Part B deductible has only been raised once in the program's 25-year history. It is now only about one-third of its original value after adjusting for inflation.

The inevitable expansion of benefits and the inability to maintain adequate cost-sharing provisions guarantee that the costs of the public plan will escalate rapidly. Since the minimum health benefit plan required by employers is identical to the public plan, mandated private health insurance costs will rise in lock-step.

The burden of these rising costs will be laid upon the general taxpayer. History is replete with examples of federal programs which started out as self-financed, or primarily self-financed, but ended up imposing increased liabilities on the general public.

Savings and loan deposit insurance was supposed to be self-financed, as were retirement benefits for railroad workers. Medicare Part B, Federal Retirement programs, and numerous welfare programs with state federal/state matching payments were all established with clear limitations on the amount of general taxpayer funds that would be used. In each program, higher costs have been financed principally general taxpayer funds.

I fail to see the policy rationale of a proposal that levies sizeable taxes on the general public, produces widespread unemployment, and at the same time, relieves large corporations of health care obligations they have voluntarily entered into.

AN ALTERNATIVE APPROACH TO THE HEALTH INSURANCE PROBLEM

In my judgement, there are three essential elements to an effective approach: retaining consumer choice; stimulating incentives for cost-conscious behavior among consumers, providers and insurers; and providing financial assistance to families who lack the necessary resources to purchase health insurance.

As a first step, I would favor utilizing the tax code as a device for creating incentives to stem the exorbitant growth in health care costs and for raising the revenues necessary to assist low-income families purchase suitable health insurance coverage suitable.

There is virtual unanimity among health researchers that our current tax treatment of health insurance encourages excessive consumption of health care services. Our health insurance system has become less of a means of insuring against risk and more a tax-free method of financing consumption of routine health care services.

Although there are many ways to change the tax treatment to improve incentives, I would favor setting a limit on the amount of tax free health insurance. Under this proposal, all employer-provided health insurance premiums above some specified level would be subject to either corporate or individual taxation. Any modification in the tax treatment should allow sufficient time for employers and employees to renegotiate wage compensation packages before the tax change becomes effective.

The proceeds of the tax cap could be dedicated to assisting low-income families finance the purchase of qualified health insurance. Not all of the 31 million uninsured lack the financial resources to purchase health insurance. About 13 million have incomes less than 130 percent of the poverty line, whereas over 12 million persons, nearly 40 percent of the total, have incomes in excess of twice the poverty line. Assistance could be targeted to those who lack adequate incomes through the use of a refundable tax credit to be used exclusively for the purchase of health insurance. The amount of assistance could be allowed to vary further within this group by income and family size.

The total amount of federal funds spent to assist families would be limited to the amount of revenue raised from the tax. According to the Congressional Budget Office, taxing annual family health insurance premiums in excess of $3,000 ($1,500 for individual plans) would raise on average about $10 billion per year during the first five full years it has been in effect. The proceeds of the tax should be adequate to provide health insurance for at least the 10 millions persons who live in households with incomes below the poverty line, and who are not covered by any health insurance, thereby completely eliminating the lack of health insurance among the poverty population.

LONG-TERM CARE

MAJORITY PLAN FAILS TO ADDRESS COST CONCERNS

During the last 15 years, numerous proposals have been brought before the Congress to provide long-term care assistance for the elderly. Each proposal has failed enactment. The principal barrier has been long-term care's exorbitant expense and the well-recognized fact that we have no known method of controlling its explosive cost growth. Nothing in the majority's recommended plan alleviates these concerns. While I have great respect for the Commission's staff, I have no confidence that the estimated cost of $43 billion will prove accurate. More likely, the estimate will prove to be only a fraction of the recommendation's eventual cost.

AN ALTERNATIVE APPROACH FOR LONG TERM CARE

My preferred approach to the long-term care problem is to use government policy to stimulate the development private sector long-term care insurance markets. The recent rapid growth in the availability of long-term care insurance is an encouraging sign that a viable private market can be developed. But, growth could be further stimulated through various means. One method would be to clarify the tax treatment of long-term care insurance to encourage individuals to purchase it when they are young and premium costs are relatively low. Another method would be to modify the tax treatment of life insurance reserves to make non-taxable the early distribution of benefits for terminally-ill persons who require long-term care services.

If measures such as these fail to prove adequate and a private insurance market fails to emerge, I would suggest that Medicare beneficiaries be given an option under the Medicare program of selecting a long-term care benefit. Under this option, all Medicare recipients would be eligible to elect fixed-dollar amounts of long-term care insurance coverage in return for paying higher Medicare premiums and deductibles.

A person electing the Medicare long-term care option would continue to receive all Medicare benefits that are currently provided. They would, however, be required to pay higher premiums and deductibles for these benefits. These higher premiums and deductibles would fully finance the long-term care coverage. None of the costs would be borne by younger generations of taxpayers.

The insurance benefit would include both a nursing home and a home-care benefit. At current prices, a $30,000 benefit would provide more than one year of nursing home care. Alternatively, it would provide about three years of a substantial amount of in-home care to supplement a family's efforts. The insurance would also act as limited asset protection. Up to a limit, the federal government would bear a specified amount of the costs of long-term care instead of requiring the individual to deplete his or her assets before becoming eligible for government aid. The primary purpose of this protection is to prevent persons who require a relatively short stay in a nursing home from depleting their lifetime assets in order to pay for the care and then having to return to their community impoverished. But it would also furnish protection to persons requiring long stays in a nursing home through a link to the Medicaid program. The link would be that the limited amount of asset protection purchased under the Medicare long-term care options would be credited against any future Medicaid spend-down liability. For example, a person who purchased $30,000 worth of asset protection would have this amount exempted from countable assets for the purpose of determining Medicaid eligibility.

The suggested approach provides not only additional benefits for persons with assets to protect, but also to the less fortunate persons who live in or near poverty, or who are medically needy. The long-term care option would provide a modestly generous home-based care benefit free of charge to many poor elderly persons. For persons eligible for Medicaid, for example, the higher premiums and deductibles would be entirely paid for by state governments, as is the case under current program rules.

My own preliminary calculations suggest that the premium and deductible payments required to finance the long-term care option are high, but not unreasonably so. My calculations indicate that raising the Medicare Part B premium by $35 per month and increasing the Part B deductible by $600 per year could finance about $30,000 worth of long-term care insurance, if persons first become eligible for benefits at age 70. At current prices, this amounts to about a year-and-a-half of nursing home care, or more than two years worth of regular home-care assistance.

CONCLUSIONS

Although I do not believe the majority's recommendations are viable, I do hope that publication of the Commission Report stimulates a spirited debate over alternative proposals. In this debate, we must recognize that the runaway costs of our health insurance system are a fundamental cause of both the gaps in health insurance coverage and the absence of an adequate private long-term care insurance market. Hence, correcting the cost problem must necessarily be part of any effective solution to these problems. In choosing priorities, we must keep in mind that providing assistance for basic health insurance to those who lack the resources to purchase it should take precedence over providing a non-means tested benefit to a demographic group for whom such insurance is already provided by government.

AMERICAN MEDICAL ASSOCIATION
1101 VERMONT AVENUE, N. W. • WASHINGTON, D. C. 20005 • PHONE (202) 789-7400

August 1, 1990

The Honorable John D. Rockefeller, IV
Chairman
United States Bipartisan Commission
on Comprehensive Health Care
140 Cannon House Office Bldg.
Washington, D.C. 20515

Dear Chairman Rockefeller:

I am honored to have served as a member of the U.S. Bipartisan Commission on Comprehensive Health Care, and most particularly I am gratified at the opportunity to serve with people the caliber of my fellow Commissioners. All approached the daunting task before us with tremendous commitment and diligence. In the process of observing them, my respect for them and the incredible responsibility they bear in guiding this country grew immeasurably. As our Chairman, you consistently demonstrated both leadership and compassion in his quest to fulfill the mandate of the "Pepper Commission." The recommendations contained in this report stand as a testament to your skill, dedication, and considerable patience and are ample proof that the Commission has met their quest.

As a nation, the United States is blessed with a healthcare system without parallel in the world in terms of quality, expertise and technology. And yet many Americans, and most critically, many young Americans do not have adequate access to that system because they lack health insurance. As a practicing physician, I see the damage done to families on a daily basis because the promise of the system is unfulfilled for them: children who cannot get vital vaccinations, pregnant mothers who do not have access to prenatal care, men and women who must forgo preventive health services and seek treatment only in acute crises--all because they lack health insurance through an employer or the state programs designated as the provider of last resort have no funds. My fellow physicians and I see firsthand the statistic of 37 million people uninsured translated into stark human terms. As I sat in the hearings of the Pepper Commission and heard heart-rending testimony from witness after witness across this country, it is clear that the gaps in access to the healthcare system exact an enormous toll on the very health of this nation. Our task as members of the Commission was to somehow reconcile a system which offers superior quality to the majority of the citizens with methods to remove the existing barriers to access. To that end, I believe the Pepper Commission has fulfilled its mission superbly.

HEADQUARTERS OFFICE: 535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS • PHONE (312) 645-5000

Rather than discard what is best about the current public/private system, the recommendations seek to build upon those strengths to reach the goal of universal access to healthcare coverage. The Commission wisely recognized that the United States must craft a solution which is uniquely American, reflecting the moral and social imperatives of this citizenship rather than adopting a foreign system merely for expediency and administrative ease. The recommendations also recognize that the health care system of this country is a vital contributor to the economic health of this country, providing employment as well as health services, and should be preserved.

There are critics of this report who allege the Commission failed to reach its goals on the basis that the Commission failed to select a discrete financing mechanism to implement our recommendations. I strongly take issue with these naysayers. Rather than fail, I believe the Commission chose the only responsible pathway to conscientiously discharge our duty. To isolate one source of revenue to the exclusion of all others would have sounded the death knell for a report which is intended to serve as a viable framework for the debate which must occur before the entire Congress and within the White House.

The importance of the Pepper Commission's recommendations lies in confronting this nation with the crying need for reform and the financial impact of implementing that reform. Reform of this magnitude will necessitate a significant shift in this country's priorities and must compete with every other federal program in an era of profound concern over the federal deficit. One need only refer to the tables of possible revenue sources included in this report to realize that selection of a singular source of financing is neither adequate nor wise. The economic climate of this country is far from static and taxing mechanisms which appear viable or attractive today can easily tarnish or vanish tomorrow given the political nature of our system. It would have been impossible to make a popular choice--popular taxes are as prevalent as unicorns. It would have been equally impossible to isolate a financing mechanism and hold it in reserve until Congress could pass this legislation. Not simply for lack of jurisdiction did we refuse to take this path, but because it would be foolhardy at best to attempt to cast a decision in stone which can only responsibly be made at the time of Congressional consideration. Unlike our detrators, we fully acknowledged we lacked a crystal ball with which to bind the future.

Effective nationwide containment of medical liability and tort system costs must also be incorporated into the federal leadership role in addressing health care availability, quality and cost issues. In the last 25 years, medical liability has become what the RAND Corporation calls "high stakes" litigation, characterized by both substantial increases in claim frequency and explosive growth in the magnitude of jury awards. These trends have led to corresponding increases in the cost of liability insurance and ultimately the cost of health care. During the 1980s, medical liability was the fastest-growing component of physicians' practice expenses, rising at an average annual rate of 21.9%.

Medical liability litigation has had a direct and negative impact on patient access to health care. A 1987 report issued by a special task of the Department of Health and Human Services documented 150 examples of access impairment related to professional liability in 26 states. A 1989 Institute of Medicine report focusing on obstetrics liability cases confirmed that many of these problems still exist and are worsening. Escalating liability insurance costs have become a major obstacle in the delivery of health care services by community and migrant health care centers.

In the few states where substantial reform of the tort system has been achieved, the trends are promising. California's Medical Injury Compensation Recovery Act has been particularly effective. Since its enactment in 1975, premiums in California have stabilized at approximately one third less across-the-board than in other large states, such as New York and Florida. The key provisions of the California reform include: (1) periodic payment of future damage awards, which allows for the financing of future needs with annuities; (2) a $250,000 ceiling on noneconomic damages such as pain and suffering, loss of enjoyment of life and other items where there are no guidelines for the jury; (3) mandatory offsets of awards where there are collateral sources of compensation that already reimburse for medical expenses or lost wages; and (4) a sliding scale limitation on attorney contingency fees, which allows a generous attorney's share (33% to 40%) to be negotiated for damages up to a $100,000, but limit the amount (15%) that could be taken for awards exceeding $600,000. The objectives of this sliding scale are to encourage attorneys to represent plaintiffs with small and moderate claims and to promote out-of-court settlement of claims by limiting the potential for a large windfall to the plaintiff's attorney.

Despite the fact that California's legislation was upheld as constitutional in 1985, effective tort reform has been blocked in all but a handful of states. Laws--and insurance premiums--now vary widely from state to state. As the federal government increasingly is called on to remedy problems of health care cost and access, the nature of the federal leadership role must be reexamined. The federal government's position as the single largest purchaser of health care services provides the basis for effective action to promote availability and control costs. Strong solutions, such as federal preemption of state regulation in this area must now be considered. California's model stands as a proved experiment and a promising model for federal application to all states that have not achieved long-term stabilization of the medical liability litigation crisis. At the same time Federal support for alternative dispute demonstration projects also should be explored.

I must sound one note of caution regarding the report. Contained in the recommendations for "cost control" is reference to the utilization of "volume performance standards" to thus regulate overall expenditures. In 1989, Congress adopted a formal system of performance standards for the Medicare program, designed to monitor increases in physician services to Medicare patients and provide data as to the underlying causes with the statutory acknowledgement that certain increases were inevitable such as technology advances, increased benefits and increases in and the rapid aging of the Medicare population (the "elderly" elderly who suffer far greater episodes of illness, of greater severity). These factors were included to safeguard access to care by requiring that the performance standard for any given year "build in" these naturally occurring increases when calculating the optimal level of Medicare expenditures. And yet, less than a year after enactment, the Administration has submitted a proposal to the Budget Summit which would arbitrarily tie the volume performance standard to growth in the Gross National Product without regard to any of the aforementioned legislative safeguards.

While respecting your commendable intentions as the author of the 1989 legislation, I view the Administration's disregard for a legislative promise with grave concern. To seek to eliminate or prevent unnecessary care is a goal I wholeheartedly share you. However, the Administration's proposal has a far different goal: placing responsibility for the reduction of the federal deficit caused by unrestrained growth and spending in other programs on the backs of the Medicare beneficiaries and the health care professionals who treat them. Consequently, I am distressed by the potential mischief which could arise from the imposition of volume control mechanisms on a new federal health care program absent binding protections from a Gramm-Rudman assault.

The Pepper Commission seeks to enhance access to health care by providing insurance to at least 37 million patients through either employer mandates or the creation of a government finance pool which subsumes the tragically underserved Medicaid eligible population. The Commission also seeks to improve access by uniformly increasing the woeful reimbursement given hospitals and physicians under the current Medicaid system, where the poor compete for health care at the mercy of 50 severely strained state budgets. If those goals are to be realized, if indeed this country intends to meet its obligation to assure the health care needs of all citizens are met, then a fortiori health care expenditures must necessarily increase. Unless this new federal program has safeguards which cannot be disregarded, which acknowledge that certain increases in health care services must occur if the promise of the new system is to mean anything, we will only exacerbate the inequities of the current system and do a grave disservice to the people of this country who can least protect themselves, the poor, the young and the elderly.

To view the submission of the final report of the Pepper Commission as a benediction would denigrate not only the laudable goals of the Commission but, more important, it would ill serve the citizens of this nation. I would be gravely disappointed if this report were to be viewed as merely the discharge of our statutory obligation. The final report does not mark the ending of our responsibility as Commissioners but rather the real beginning. We have crafted a blueprint to assure the health of this nation and we must now bring that plan to fruition. While arduous, the task of reaching a consensus built upon lengthy debate and investigation pales in comparison to the feat which lies ahead of us all--securing the passage of legislation which embodies our recommendations. The accomplishment of such landmark and crucial legislation must be a job shared by all citizens, for certainly the benefits of universal access to health care coverage will flow to all and for generations to come. This report is truly a "Call To Action," not only to our government leaders, but to the nation as well. Physicians, patients, business and labor leaders--all must join with our elected representatives in the battle and fight to preserve the future of this country by insuring the health of our families and children. I truly believe the Pepper Commission has more than lived up to its commitment to provide a responsible and viable plan of action for the American people. Mr. Chairman, I stand ready to assist you and my fellow Commissioners in any way I can to make these recommendations a reality.

Very truly yours,

Jim

James E. Davis, MD
Presidential Appointee
U.S. Bipartisan Commission on
Comprehensive Health Care

JED/fhl

"PRINCIPLES FOR HEALTH SYSTEM REFORM"
Additional Views on the Work of the Pepper Commission
by U.S. Senator Dave Durenberger

I. THE COMMISSION'S SUCCESSES AND SHORTCOMINGS

As a vice chair of the Pepper Commission, I'm frequently asked: "Was the Commission a success?"

My answer is a qualified "Yes." The Commission had a number of successes. But, there were some serious shortcomings, as well.

On the positive side, the Commission labored long and hard under the dedicated leadership of Senator Jay Rockefeller to fulfill its statutory charter to make public policy recommendations on health care access problems of the low-income elderly, the uninsured and families confronting long-term care needs.

This experience was especially poignant because it included the loss of our ultimate namesake -- and original chairman -- the late Congressman Claude Pepper. Congressman Pepper's personal commitment to solving these problems is well-known. And, his lifetime of concern for the elderly and less fortunate set high standards for our Commission's work.

The Pepper Commission was unprecedented among public policy task forces and private coalitions in that twelve of its fifteen members are chairmen and ranking members of the principal health policy committees and subcommittees in the United States Congress.

These Members -- and the three private sector appointees -- have diverse backgrounds and points of view. So the first success, perhaps, was that we assembled, worked so well together, and agreed on anything at all.

Secondly, we were brought closer together in our common understanding of the seemingly intractable issues of cost, inefficiency and inequity. These issues now threaten the very foundation of our health care system -- a system, paradoxically, that is capable of providing the best medical care in the world.

A third success was agreement on the important role that health care providers must play in defining future health policy. We also endorsed efforts to make providers more accountable for constraining costs and for defining and improving medical outcomes.

Fourth, there was a strong consensus that the national social insurance system must be both overhauled and used to supplement individual resources -- especially for low-income people -- for basic health services and for long-term care needs.

And, the final success is that we agreed in principle to move toward more uniform national standards for health benefits and for access to social insurance protection.

* * * * *

Despite these successes, we did not always agree on the specifics of how to accomplish these ends. And, in my personal view, there were some important shortcomings in the Commission's final recommendations.

The first, and main shortcoming, is the Commission's recommendation to mandate responsibility for financing access to basic health benefits on employers.

My concerns with this recommendation are detailed more fully below. But, in general, I believe it represents a major shift in financing responsibility -- with serious side effects -- and without fundamental reforms that address underlying problems of cost and of equity.

The second shortcoming I see is a failure to require consumers -- to the extent they are able -- to share responsibly for the cost of financing access.

A third shortcoming is the Commission's failure to deal with the very large subsidies in the federal tax-code for employer-based health benefits. These subsidies contribute significantly to dividing Americans into "haves" and "have-nots" for health insurance, depending on whether they are employed by a firm that has the subsidy and offers benefits.

A fourth and final shortcoming is a failure to address restructuring of the Medicare program. In its twenty-fifth year, Medicare is long overdue for serious attention to its benefit, financing, and beneficiary cost-sharing provisions.

In fact, Medicare will be in a serious deficit within a very few years. The goals of restructuring should be to position this vital program for the 1990's, and to assure its continued integrity as a vital part of our Social Security system, well into the 21st Century.

* * * * *

With this as general background, I measured the Commission's proposals against my personal benchmark of whether each has appropriate economic and quality incentives for all the major "stakeholders" -- individuals, employers, private insurers, government, and providers of health care services.

Any set of proposals that fails to significantly engage all of these stakeholders in the outcome will only worsen the central underlying problems facing our health care system. Those fundamental underlying problems include:

** Excessive costliness;

** Public and private health care financing arrangements that have unsound economic incentives for individuals and providers; and

** Maldistribution of -- and excess capacity in -- medical care resources.

Measured against the "stakeholder standard", the two principal proposals -- the employer-mandated health benefits system and the long-term care financing proposal -- are both seriously flawed. In particular, both fail to engage one or more of the key stakeholders in ways that would counter these central underlying problems.

However, rather than attempting to address the Commission's recommendations section by section, I believe it is more important to take the longer view, and sketch out the reforms that I think must occur over the next several years and the principles that should underlie them.

II. PRINCIPLES FOR FUNDAMENTAL REFORM

America is a pluralistic society, a fact that's as evident in health care as in any other area of life. And, as we pursue fundamental reform, each of at least five "stakeholder groups," has characteristics or behavior that can contribute either positively or negatively to fundamental reform.

** **Individuals**, for example, seek to minimize the risk of expensive medical bills by purchasing a private health insurance policy. Or, as is far more common, they obtain their health insurance as part of a compensation package offered through their employer. Separately, they may be protected by public programs such as Medicare or Medicaid.

** **Businesses** and other employers often provide health benefits to attract workers. But, they pay for these benefits by charging higher prices to consumers, reducing other compensation or benefits, or by decreasing dividends to their shareholders.

** **Government** programs, financed through income and payroll taxes, serve to distribute the financial risk of medical care across generations (Medicare), across income classes (Medicaid), or across classes of individuals (special purpose block grants).

** **Private insurers** collect premiums from individuals or groups in return for defined financial protection in insurance benefits.

** **Medical care providers** -- hospitals, doctors and others -- are directly involved with each of these groups.

Given these complex interrelationships, it's tempting to throw up our hands in utter frustration over the likelihood of achieving real reforms. And, I don't want to gloss over the difficulties we face.

But, I sincerely believe that with strong leadership, and by keeping our sights on some fundamental principles during the course of public debate, we can take the steps necessary to put the health care system on stronger footing. And, at the same time, I firmly believe we can assure that all Americans have their basic health care needs met.

* * * * *

Returning to the five basic "stakeholders," the following are my thoughts on the roles, responsibilities, and principles that should guide fundamental reform.

** **Greater responsibility for individuals**

Individual citizens are at the very heart of reform. We are patients, taxpayers, employees, and employers. But, whatever hat we happen to be wearing, individuals must have a reasonable stake in the cost of medical care, regardless of whether we obtain protection through private insurance or public programs.

The only exception to this principle should be individuals who are disadvantaged economically -- individuals who should receive special consideration in any publicly financed proposal.

Aside from this caveat, having an economic stake in our health benefits will prompt all of us to become more involved in knowing what our insurance covers, in making personal decisions about what services to use, and in taking steps to maintain and improve our own health.

** **Fairness, equity and responsibility for employers**

Historically, an increasing number of employers have provided health benefits voluntarily, just as they voluntarily have offered pension and other benefits to attract and retain workers.

Most Americans also look to the workplace to obtain financial security. And, we view the workplace as the source of benefits other than wages that further buttress our income security needs.

However, health benefits are very prone to the realities of human nature. In particular, many individuals tend to consume more insured services than they would if they had to bear the entire cost themselves.

This "cost insulation" problem is made worse by the fact that the health benefits provided by corporate employers are a fully deductible business expense for tax purposes. And, unlike wages, health insurance benefits are neither taxable income to individuals, nor included in the base of income subject to Social Security and Medicare taxes.

So where is the real economic stake -- in how much health care services cost -- when both the employer and its employees are so insulated from the true cost of the benefit program?

Indeed, all tax-paying Americans subsidize these benefits because of how they are treated in the tax-code, especially those tax-paying Americans who are not fortunate enough to be protected by health insurance purchased through employer groups.

To reverse these negative forces, employers must assume responsibility for restructuring the benefits that they offer to employees to encourage employee cost-sharing and provider cost containment, and to assure that they are buying only necessary and high-quality services.

Although selected employers are taking steps in this direction, not enough is being done. And, the extraordinarily generous tax treatment of health benefits virtually guarantees that progress on this front will be sluggish and ultimately inadequate.

* * * * *

On one hand, it's not illogical to approach universal access by building on the strong base we already have in employer-provided health benefits. Few would disagree that society benefits from the fact that nearly 85% of the American workforce is protected through the voluntary health benefit offerings of employers.

However, to now mandate that every American employer provide health benefits represents a perilous leap for government.

In effect, government would be intervening in the private exchange of value that occurs between workers and employers over labor services, by dictating terms of the exchange. This is especially troublesome when the intervention is on behalf of something not directly connected to conditions of employment.

Of course, government has historically intervened in the workplace to introduce some basic societal ground rules that employers must follow. But, these have been in areas (occupational safety, non-discrimination, minimum wage) that relate directly to ordinary conditions of employment. And, they are designed to assure that minimum standards of safety and fairness govern the workplace.

In my mind, provision of a fringe benefit, such as health insurance, does not fall into this realm. And, I fear it may be fundamentally inappropriate for government to use its regulatory power to mandate that employers incur such a significant (and growing) labor cost.

This would be especially burdensome for small employers, where even government subsidies -- or limits on aggregate liability -- may not be sufficient to protect the employer from erosion of already tenuous profit margins.

This separation of existing workplace mandates and proposals to now mandate health insurance should not be dismissed as a "distinction without a difference."

To use one example, when Congress periodically votes to raise the minimum wage, Congress and the business community have a clearly delineated idea of what the cost of such a change will be, and how it will affect various industries.

But, by contrast, if Congress mandates that all employers provide health insurance, it will be imposing a cost that could vary significantly from company to company, from region to region, and among employees who are single and those who have dependents. And, it is a cost with annual increases largely out of the control of either employees or employers.

Another example helps illustrate the significance of the cost issue, especially for employers with lower-paid workers.

The minimum wage standard remained unchanged at $3.35 per hour for nine years. After months of often bitter public debate, the law was changed so that it would rise, over 2 years, to $4.25 per hour by April, 1991. That's a 25-percent increase over the 2-year period, very significant, but also historically justified. And, perhaps even more important, it can be planned for, and adjustments can be made.

Compare this to the burden of imposing health benefits coverage on an employer.

If we assume that the average cost of a family health insurance plan is $2,500 per year (and that is a low cost), and if we mandate that an employer would be required to pick up the extra $2,500, that would mean that the employer would be paying **an additional $1.20 per hour** to cover each employee.

That represents an initial 30-percent cost increase for **each minimum wage employee**.

And, although the impact would be felt most dramatically on employers with lower-paid workers, this extra $2,500 would also represent a 12-percent cost increase for employees earning $10 an hour.

Furthermore, since the cost of medical care rises every year, the employer could face sizable annual cost increases that would be largely beyond its ability to control.

It is possible to cap the employer's aggregate liability, but any expenses in excess of a cap would have to be publicly financed. And, currently, there are no really effective controls on the underlying health care costs that would have to be absorbed either by employers or the American taxpayer.

Of course premium expenses also vary widely around the country. And, this makes it more difficult for employers in high-cost areas to remain competitive **and** provide benefits.

This reality also sets up some problems relative to a uniform tax alternative to buy employees into a public program, since there would be incentives for employers in higher cost areas to automatically opt for the public program rather than purchase private insurance.

Finally, if health care is as essential as I believe it to be, then it should be the responsibility of society-at-large to make sure that all individuals have financial access to needed services.

For all of these reasons, I am reluctant to support mandated health benefits, or its variation, the so-called "pay-or-play" employer tax.

** **Providers must be full participants in fundamental reform**

Health care providers have historically been responsible for assessing the need for services, the quality and quantity of services to be furnished, and the price of their services. But, as concerns have been raised about access, cost and quality of health services, providers have experienced some significant losses in autonomy in exercising these prerogatives.

In light of these trends, it is imperative to the future of medical care that the individuals providing care do so with great regard for quality and cost-effectiveness.

And, providers must participate constructively in major health care issues such as medical education, research into disease prevention, treatment and medical outcomes, and in the design of cost-effective delivery and financing systems.

Providers are the backbone of what health care is all about. And, they must be engaged in all phases of efforts at major health system reform.

** **Insurance reform must focus on the small group market**

Private insurance companies financed about $150 billion of the over $500 billion spent last year on health care in this country. But, until quite recently, the primary role for these companies was to collect premiums, pool risk for their policyholders, and process claims from medical care providers.

In recent years, however, the rise in health care costs and other market forces have been a catalyst requiring more of insurers in designing cost-effective benefits. The competitive pressures in the insurance market have also stimulated less desirable practices such as selecting out poorer risks, or engaging in rating practices that precipitate abrupt, sizable increases in premiums.

Of course, insurance companies are private firms. But, the very nature of this product (health care benefits), places them squarely in the debate over the future shape of health care financing in this country. It also means that they cannot evade social-welfare judgments on certain of their practices in the marketplace.

Consequently, insurers must also undertake reforms if they expect to sustain their current roles in health care as insurers and as administrators of benefit plans. In particular, there is evidence that certain enrollment and rating practices in the small group market are impeding the availability of affordable benefits for small employers. These practices must be corrected, where necessary by government, and where appropriate by the national government.

** **Government must restructure and reform its health programs**

Government already has a principal role in financing access to health care through the Medicare and Medicaid programs. To a lesser extent, government is also an important stakeholder via other, smaller programs such as community health centers or immunization programs. And, government also has important roles to play in financing research, in public education, and in regulating the private insurance market (the latter traditionally at the State level).

Many of these responsibilities of government in the health field are under active review elsewhere. So, for purposes of the charge to the Pepper Commission, I will focus on what responsibilities I think government should assume for financing access to basic health care and long-term care services, and for private insurance regulation.

Historically, there have been certain functions and responsibilities that we in American society have assigned to government. One is to foster a free-market economy, but with the ability to intervene judiciously in markets that do not appear to be fulfilling our expectations -- making sure that the public's interests are being well-served.

For example, in private health insurance, the government plays an important role in consumer protection and in stabilizing the market by setting financial solvency and other similar standards for insurance companies. To the extent that there is strong evidence that the private market is dysfunctional -- and adversely affecting individuals' and groups' ability to buy policies -- government can and should take steps to correct those problems.

Separately, we have granted both state and federal government large responsibilities for organizing the financing of health care services through Medicare -- for people eligible under the Social Security system -- and through Medicaid -- for people eligible primarily due to low-income.

These two programs present very different problems in their current design and administration. But, principles of equity and uniformity in eligibility and benefits, efficiency of administration, and incorporation of sound economic principles in the design of the underlying financing and cost-sharing mechanisms, apply to both. Government must assume primary responsibility for restructuring and reforming both these programs in accordance with these principles.

With respect to Medicare, the government has a standing commitment to the Social Security system -- of which Medicare is an important part. And, we should reassess Medicare to assure its continued viability in the future.

Unfortunately, the Pepper Commission did not address the looming financing deficit and other problems in the Medicare program, with the exception of recommending the addition of certain preventive benefits and subsidies for the low-income elderly.

Under Medicaid, it is imperative that the inequities in eligibility, benefits, and administration be addressed. In this regard, the Pepper Commission took major steps in the right direction, by recommending that the program be substantially revised to make it more uniform, nationwide.

However, since Medicaid is jointly-financed and administered, the relative responsibilities of the States and the federal government must be reviewed and clarified before reform can proceed.

III. A Basic "Blueprint for Reform"

Based on these underlying principles, I support the following basic "Blueprint for Reform" in health care. The overall premise for this "Blueprint" is that we should correct the serious problems in the private and public sectors, while recognizing the valuable contributions both can make to protecting our citizens.

I'm quite aware that these reforms, although incremental in character, are both controversial and substantial. But, if they can be accomplished, I believe our health care system would be on much stronger footing for at least the next two decades. And, I believe we would be much closer than we are today to achieving the Commission's major goals.

Briefly, the major components of this "Blueprint for Reform" would:

** Encourage optimal functioning of the private health insurance market by enacting Medigap and small group insurance market reforms.

** Provide a basic health care safety net for all -- not just some -- of our poorest citizens, by restructuring the Medicaid program with uniform national standards for eligibility, scope of benefits and provider payment.

** Restructure the benefits, financing and beneficiary cost-sharing provisions of the Medicare program, in order to keep Medicare a strong and vital part of the Social Security system.

** Address the larger issues of cost containment in health care that are beyond what individuals, private insurers, or employers are capable of dealing with. This includes a complete reassessment of the federal tax treatment of health benefits for individuals and companies.

** Assess the risk to basic income security that long-term care represents. And, design a program that incorporates principles of insurance and responsible individual cost-sharing, in preference to creating a major, new social insurance entitlement program.

* * * * *

To build on this "Blueprint for Reform," I intend to develop and introduce legislation in each of the areas just summarized, incorporating the general principles that have appeared throughout this discussion.

IV. A CALL FOR PRESIDENTIAL LEADERSHIP

Serving on the Pepper Commission was an educational opportunity that I valued highly. I also valued working with the thoughtful and dedicated people who served on the Commission, and who are exemplified by the Chairman, Senator Jay Rockefeller.

But, do I think that the Commission's recommendations will be the last word on universal access to health care, or on the potential design of protection against long-term care? No, I do not. And, can any one of us -- on or off the Commission -- expect to achieve these important goals on our own? Again, the answer is a realistic "no."

These issues speak to the very fabric of our society. And, they are too large and complex for any one group to solve them singlehandedly.

Most of all, they require the highest kind of executive leadership that can be provided only by the President of the United States.

I look forward to working with the President, my colleagues and my constituents in addressing these issues. And, let there be no doubt. Our task will take time, hard work, and strong political will. But, our task must be done.

8/16/90

BILL GRADISON
2D DISTRICT, OHIO

MARGARET TOTTEN
ADMINISTRATIVE ASSISTANT

COMMITTEES:
WAYS AND MEANS
BUDGET

2311 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
TELEPHONE: (202) 225-3164

6010 FEDERAL OFFICE BUILDING
550 MAIN STREET
CINCINNATI, OH 45202
TELEPHONE: (513) 684-2456

Congreſs of the United States
House of Representatives
Washington, DC 20515

August 1, 1990

Hon. Jay Rockefeller, Chairman
The Pepper Commission
140 Cannon House Office Building
Washington, D.C. 20515

Dear Jay:

Enclosed are my dissenting views for inclusion in the Pepper Commission's final report.

As you know, while we share the same goals, I wasn't able to support many of the Commission's recommendations. The enclosed statement further explains the reasons for my dissenting votes.

I want to commend you once again for the fine job you did as our chairman. It was an honor to serve with you.

Sincerely,

Bill Gradison
Vice Chairman

Enclosure

Dissenting Views

Honorable Bill Gradison
Vice Chairman

The legislation creating the U.S. Bipartisan Commission on Comprehensive Health Care required the Commission to "...make specific recommendations to Congress on federal programs, policies, and financing needed to assure the availability of comprehensive long-term care services for the elderly and disabled, comprehensive health care services for the elderly and disabled, and comprehensive health care services for all individuals in the United States."

The Pepper Commission, our able Chairman, and our energetic staff worked long and hard to attempt to meet this charge laid out by Congress. The Commission was free of partisan bickering, and took its work seriously from beginning to end. Nonetheless, I cannot support the thrust of the Commission's recommendations. I regret that unanimity eluded us. We share the same goals but differ on how to reach them.

Unfortunately, the Commission failed to meet the charge of making specific financing recommendations, and, as a result, the report is unlikely to move the Congress towards action. In fact, the huge price tag of at least $67 billion tells me that the Pepper Commission's recommendations lie beyond the outer boundary for serious discussion of health care plans in the future.

The lesson here is clear. To be taken seriously, those who wish to move policymakers will have to craft their proposals to fall somewhere between the status quo (with its unacceptable gaps in health insurance for tens of millions of Americans) and the Pepper Report (with its unrealistic price tag), and they must provide realistic financing.

Consider this: $67 billion in annual new spending is itself larger than all but six of the federal budget's 18 spending functions. Only the National Defense, Health, Medicare, Income Security, Social Security, and Net Interest budget functions are larger. It is more than 10 times the cost of the catastrophic health care program that was repealed primarily because of its financing. To put this in further perspective, $67 billion would require a surtax of over 10% on all individuals and corporations paying federal income tax. Not a likely prospect. Or, put another way, it would cost over $870 per year for every household that pays federal income taxes. My congressional district may be atypical, but I'm sure that my constituents are unwilling to fork over that much more of their incomes to Uncle Sam.

Financing aside, the Pepper Commission did reach broad consensus in several important areas: the priority which should be accorded to maternal and child health programs, the need for insurance reform, and the merit of building on our job-based health insurance system. Unfortunately, the Commission did not always follow the logic of its own ideas, most notably by failing to explore ways in which long-term care could be built on an employer-based model rather than on a government-based model.

While the Commission did not express priority between the uninsured and long-term care proposals, the difference in the votes within the Commission is significant. The issue is not so much one of cost alone, but popular support as well. The long-term care recommendations were approved by the Commission by a much wider margin than the recommendations for the uninsured. This significant difference in the vote is indicative to me of the politically popular nature of long-term care initiatives, despite the higher price tag. My concern is that these new initiatives will move forward at the expense of expanding access to primary and acute health care services and we will still have millions of uninsured. We will still have hospitals closing, further limiting access.

PROBLEMS WITH THE CURRENT HEALTH CARE SYSTEM

That there are problems with the health care system in this country is not in question:

- far too many Americans lack health insurance
- health care costs continue to increase at unacceptable rates, while at the same time there is a growing sense that we are not certain what we're buying
- deteriorating financial conditions of essential health providers threaten to undermine their ability to serve the public

Yet at the same time the country faces these issues, there does not appear to be a constituency for pumping very large amounts of new money into the present health care system. Certainly, there is no evidence that the public feels undertaxed. Nor is it even certain that such large new expenditures will in reality adequately address the problems of our current system.

The fact is that the federal government has failed to carry out the promises already made to provide health care for the poor and other special populations. For example, only about 42% of the poor are now covered under Medicaid, where limitations on eligibility, the scope of benefits, and the level of reimbursement undermine its value to those it was intended to serve. To a lesser extent, Medicare is not fully meeting its promise, especially with regard to covering the catastrophic costs of acute care. Moreover, the one-size-fits-all design of the Medicare benefit package fails to meet the varied needs of the elderly.

Why Medicaid and Medicare aren't doing their jobs well is an important question, and one not much explored by the Pepper Commission. But whatever the reasons, it is simply questionable public policy to make new health care promises to groups presently lacking health insurance entirely, or even lacking adequate insurance, when existing programs aren't meeting their responsibilities.

There is an unreal quality to the Pepper Commission's proposals for more than $67 billion of new spending by the federal government alone, when the Congress was advised in the President's 1991 budget proposal that the present value of the deficit in the Hospital Insurance Trust Fund (Medicare Part A) could be $250 billion. I am reminded of Milton Friedman's observation:

> "Although the purveyors of health care may initially get additional resources by tapping the government till, that is a transitory phenomenon. When the government is taking over any activity, there is more money available...once the government has taken it over, the situation changes. Politicians have to move on to new fields and take over new areas in order to get votes. The result is that those areas already taken over get starved. Instead of there being more funds available, there are less."

Like most economists, politicians should know we live in a world of scarce resources. While the Pepper Commission's charge was to recommend action, we cannot overlook the fact that if its proposals became law, fewer resources would be available for other worthy causes: education, housing, the homeless, child care, the environment, or raising future living standards by cutting the deficit (and raising national savings), to name just a few.

COVERAGE and MANDATES

The Pepper Commission wisely emphasizes the employer's role in health care, and I support an employer-based approach. It is the distinctive feature of the U.S. system just as the provincial-based plans are in Canada, and the centralized, government-provider system is in Britain.

Nevertheless, to recommend mandatory employer payments for most employee health care costs -- even if delayed by a "trigger" -- merely assures that the Commission's recommendations won't be part of the serious debate in Congress. Small businesses -- already adjusting to the new mandate of a higher minimum wage, and legitimately concerned about other cost-increasing mandates such as Social Security tax boosts, clean air legislation, and new laws covering the disabled -- will object strongly to the plan, and they will be justified in doing so.

An employer mandate for health insurance is based on a false premise, namely, that small businesses are able but unwilling to meet their social responsibilities. This may be true of some, but the overwhelming evidence is that employer-based health care plans are simply unavailable and/or unaffordable to many small businesses. Especially in a tight labor market, it is in the interest of small business to offer health benefits in order to be competitive in recruiting and retaining employees. But the fact is many cannot afford to do so. To make matters even worse for small businesses, the Commission's recommendations would result in a $10 billion shift of health care costs from larger to smaller businesses.

My own analysis is that the Commission's recommendations for insurance reforms -- which I support -- will increase the availability of health insurance for small business, but they will also increase the cost. The cost increases would arise in part from prohibiting medical underwriting (e.g., consideration of pre-existing conditions) and from an insurer having to guarantee acceptance of all small groups wishing to purchase health insurance.

Philosophically, there are valid pros and cons to mandates. Over the years, mandates have been imposed for the minimum wage, workers compensation, Social Security, unemployment compensation, overtime pay, and so forth. But to pile mandate after mandate on employers without considering cost is to lower the general level of economic activity and employment thereby harming the very individuals meant to be helped.

In my view, the Pepper Commission has understated health insurance costs for its own benefit package. From my reading, the annual premium costs, even for a basic benefit package, are significantly higher than the Commission estimated. A health insurance mandate imposing new costs on the employer will, in some cases, result in job losses. Employers with many part-time workers will simply cut back rather than pay the extra tab. Those fortunate enough to keep their jobs will see the purchasing power of their pay checks reduced over time as the mandate phases in. In some cases, those individuals who already have access to public hospitals or community health centers, may be worse off with the coverage they are required to buy because they would be required to pay, at least in part, for care they now receive for free.

Like it or not, mandate-induced job and pay losses must be balanced against the socially desirable goal of assuring employees and their dependents access to quality health care. Employer mandates of this type should be opposed until health costs are brought under control -- at least until the per employee costs for small businesses are brought in line with those of larger, generally self-insured, businesses. To do otherwise would, in effect, mandate higher costs for smaller employers than for large, hardly an enlightened public policy.

COVERAGE -- THINKING REALISTICALLY

Universal access to quality health care is a worthy goal, but the costs -- not alone financial -- of reaching this goal suggest setting a more limited, more attainable objective. The problem with the present system is not the fact that some lack health insurance; it is that so many lack health insurance. Were the number lower, the health needs of the uninsured could be met through public hospitals, philanthropy, community health centers, even cost shifting.

Designing a system with a goal of say, 95% coverage, hard as that is, will be infinitely easier and less intrusive than a system meant to cover 100%. Even the Pepper Commission fails to assure 100%. What about uninsured employees of small businesses if the "trigger" is not pulled? Medical expenses not covered under the Commission's mandated health package? Premiums and deductibles which must be paid by beneficiaries? Prescription drugs and dental care? Better to acknowledge that 100% is unrealistic and act accordingly than to pretend otherwise.

The Commission's "play or pay" plan has a basic political failing. Under its recommendations, about 70 million persons would be covered under the public plan, not counting 33 million Medicare beneficiaries. Over 100 million Americans would then look to the federal government for their health insurance. As a result, the political pressures to increase benefits would likely result in costs to taxpayers far above what even the Commission estimates.

LONG-TERM CARE

The Commission's assumptions about the problem of long-term care don't hold up very well in the face of the facts. Consider, for example, the widespread belief, reflected in the Commission's recommendations, that only a relatively small number of Americans will ever be able to afford the premiums for private long-term care insurance, even among the baby boom generation. Yet, as we heard in testimony before this Commission, the Brookings/ICF model estimates over 50 percent coverage if people were to begin paying during their working years or use some of their assets in their later years. Moreover, we simply don't know how many people with substantial assets could pay premiums for such insurance. Yet the Commission operates on the assumption that a new and very costly non-means tested entitlement program is the answer.

There are two basic issues today in the financing arrangements for long-term care: (1) the emphasis on institutional (nursing home) care rather than community (home) care and (2) the spend-down requirements of Medicaid. Happily, insurance is now becoming available permitting those who can afford it and qualify for it to protect themselves through the private sector. Unhappily, the non-means tested (social insurance) proposals of the Pepper Commission, rather than encouraging a private sector response, may actually retard it. And even more ominous, the losers, if a major new social insurance program is adopted, may very well be the poor. While more persons may be covered, the scope of benefits available could be drastically reduced.

As Isabel Sawhill of the Urban Institute has pointed out, since 1962 all of the growth in federal spending, as a percentage of GNP, is accounted for by two non-means tested social insurance programs -- Social Security and Medicare. Even more telling, recent Congressional Budget Office projections indicate that if current spending continues at the same level, by 1995 these two programs will account for almost one third of the entire federal budget. That they have accomplished a great deal and are enormously popular is without question. But the real question is whether a large new non-means tested social insurance program can be adopted in the face of strong public opposition to higher taxes and major competing demands for existing revenues.

My thinking about long-term care has been influenced by the University of Pennsylvania's Mark Pauly, who comments:

> "In a world of unlimited resources, one would surely not want to ask people to reveal their wealth levels before they get public benefits, or to sacrifice some of the bequest they intended to leave. But in the real world of constrained resources, there has to be a cheaper way to deal with the feeling of 'stigma'".

Fortunately, there is a cheaper way. Long-term care is an insurable event. Obviously, few families can afford a $25,000-a-year nursing home bill, but the evidence is that a large and growing number of Americans can afford long-term care insurance. And the increasing affluence of many elderly, if not the elderly as a group, makes it possible to redesign the Medicare benefit package so that those who wish to have at least partial protection against long-term care costs can have it, without increasing the costs of the Medicare program.

MY RECOMMENDATIONS

Unlike those who list the new health care benefits they favor, and then explore how to pay, I start with the money, since that is the limiting factor. Before expensive new programs are considered, we should seek budget neutral means of paying for much needed improvements to existing programs.

What then do I favor, and how would I finance it?

Health Care Access

The present tax treatment of health care expenses is perverse and should be changed. Full deductibility for the employer, coupled with complete exclusion for the employee, has four undesirable results:

- Tax subsidies for health insurance for those workers who have coverage, but not for those workers who do not;

- Tax subsidies for workers covered by health insurance but not for non-workers;
- Larger tax subsidies for higher-income taxpayers than for those in lower brackets; and,
- Higher tax subsidies for more expensive benefit packages, regardless of income.

Capping this tax benefit could help finance a refundable tax credit for the purchase of health care coverage for those not covered by employer-provided insurance, Medicare, or Medicaid. The credit could "slide" depending on income and family size. Initially, the credit might be limited to maternal and child health benefits.

Moreover, if employers were required to offer, but not to pay for, group health coverage, the availability of the credit may induce employers voluntarily to pick up all or a part of the costs in excess of the employee credit. Further encouragement to small business could come from extending to the self-employed the same full deductibility of health insurance premiums provided corporations.

Long-Term Care

Changes in long-term care can be financed by offering actuarially equivalent and budget neutral packages to new Medicare beneficiaries and by bringing the Medicare eligibility age in line with the normal retirement age for Social Security benefits. This would also produce substantial savings to the general fund under Part B. Such a change would reflect the increase in life expectancy over what it was when Medicare went into effect nearly 25 years ago.

Under these approaches, at least two new options should be considered under Medicare in addition to current benefits:

- Current benefits with higher deductibles and/or premiums coupled with catastrophic acute care protection; or
- Current benefits with higher deductibles and/or premiums coupled with long-term care protection. Raising the Part B deductible would provide funds that could be applied to a long-term care benefit.

The Part B savings to the general fund from the change in the age for Medicare eligibility could finance:

- Increasing the income and asset limits for sick spouses to the level set under the spousal impoverishment provisions of the Medicare Catastrophic Coverage Act; and

- Broadening home health coverage under Medicaid.

In addition, at very little expense to the Treasury, taxpayers should be permitted to use part of their life insurance reserves, pensions, or IRA's to purchase long-term care protection without triggering a taxable event. The current tax treatment of employer-paid health insurance should be extended to employer-paid long-term care insurance. States should be granted waivers under Medicaid to experiment with stimulating the development of affordable private long-term health insurance.

CONCLUSION

I find the Commission's recommendations so costly that they are unrealistic. They rely too much on coercion and too little on state and local initiatives and private sector efforts. I believe that in tackling the nation's health care problems, the American people will respond better to incentives and fewer regulatory barriers than to a gun at their heads.

The track record of federal programs in dealing with all manner of human problems should give us pause in trying to lay out a strategy and a fixed time-table as the Commission has done. Best to take measured action now and evaluate our progress on a regular basis.

The Pepper Commission's report is but one of many on reforming our health care system that will be issued this year. Its recommendations will help initiate, not end, public discussion about health care.

Regrettably, after much hard work and unquestioned good intentions by all, the Pepper Commission's report will only raise false hopes. Instead of focusing on the possible, the recommendations make promises that simply cannot be kept.

DISSENTING AND ADDITIONAL VIEWS
ON THE PEPPER COMMISSION RECOMMENDATIONS

BY

U.S. SENATOR JOHN HEINZ (R-PA)

The report of the Commission marks a truly auspicious occasion. That this Commission even survived the firestorm that consumed the Medicare Catastrophic Act demonstrates the commitment of all Commission members to set forth a blueprint for America's future.

These recommendations acknowledge the national urgency of our mission. America's health delivery system is fundamentally flawed. It is absolutely perverse that, in a nation of such great affluence as ours, we operate under a system that is based on ability to pay rather than on medical need. We have a health care radio dial programmed to pick up dollars -- with only static as a response for the poor and uninsured.

We have the highest infant mortality rate of any industrialized country in the world. Twelve million of our children dress each day without a thread of insurance protection. Families are often forced to split apart to qualify for minimum access care through Medicaid. Aged and disabled Americans consistently sacrifice their freedom and dignity in institutions because they lack available and affordable care in their own communities.

What has moved this Commission is the belief that access to adequate health care is every citizen's birth right. We have examined with great interest the successes of other nations in assuring universal access to quality care. I myself have been particularly struck with the program developed by our neighbor to the north.

Canada's model of health care started more or less independently at the provincial level and remains today run almost entirely by the provinces. It not only recognizes the unique characteristics of each of the provinces, but it works extremely well in delivering health care to all citizens. While we cannot replicate Canada's approach, nevertheless, we need to reform our health care system so it is more like theirs -- and less like ours -- when it comes to assuring access, quality and controlling costs.

I share the goal of our Commission to deliver on the promise of a comprehensive health care reform initiative that gives every American, in the immortal words of Frederick Douglas, a "Fair start and an equal chance in the race of life."

ACUTE ACCESS ISSUES

While I was prepared to support much of the work of the Commission, I believe that the Chairman's recommendations for acute care perpetuates the proven flawed approach of the government in Washington dictating what and how everything should be done. These recommendations, in too many ways, take us a step backwards -- not a step forward -- down the road toward universal access and quality services. Instead of the Chairman's acute access plan, I support a two part job-based health plan administered by the states. Under this plan, all employees working 30 or more hours a week -- and their dependents -- would have access to a package of basic benefits under the employer's job-based policy; with a voucher provided the worker by the employer; or by the employer purchasing coverage through the state plan. Employees working less than 30 hours a week -- and their dependents -- and all unemployed persons without insurance, would be covered by a new non-means tested public plan.

Primary financial and administrative responsibility for coverage under this new plan would rest with the states, although a substantial financial obligation would remain in Washington. The present Medicaid program would be completely abolished and all state dollars now committed to long term care would be concentrated on the public acute care plan. Long term care services, as with Medicare now, would become a federal responsibility.

While I have described this proposal in detail to the Commission during the course of several months of deliberation, let me state for the record some of the more pertinent details. Under my proposal, for example, states could administer the program themselves, or contract with one or more carriers or health plans to administer it for them. States would have great flexibility to use whatever methods they deem appropriate to control the costs associated with their plans, short of reducing the required minimum benefits or excluding any eligible individuals or groups. Because this plan also assumes federal responsibility for all long term care services not covered by Medicare or private insurance, states will be able to dedicate the full dollar amounts now spent on both acute and long term care fully to acute care only.

The Chairman's acute care proposal differs from mine in several other important and critical ways. First, the Chairman's plan amounts to a federal pre-emption -- and ultimately a federal takeover -- of both our public and private acute care delivery system by placing major fiscal responsibility and administrative prerogatives in the lap of Uncle Sam and centralizing all controls in Washington, D.C., not the states. This necessarily creates a bureaucratic monolith, by definition unyielding and inflexible, for which all in need of health care will pay a high price.

One example of that price will be the impact on hospital providers, particularly those serving statistically anomalous populations. Historical lessons learned from our Medicare experience tell us that the public loses when the federal government pre-empts state roles in cost containment. With DRGs, for example, we have run into major inequities and problems with reimbursement based on regional differences in practice and cost. So-called "Lugar Hospitals" face financial disaster by virtue of their defined "rural" locations and their actual "urban" costs. The federal controls and national rate setting in the Chairman's proposal perpetuate the present reality and increase the future risk of such myopic misappropriations -- what we might refer to as "Beltway Vision." This proposal ties the hands of the states rather than encouraging the greatest level of state and private sector involvement, not only in meeting the unique local health care needs, but more importantly, in stimulating program innovation, implementation, and cost control.

Another extremely serious shortcoming is that the Pepper Commission itself was unable to reach consensus on any cost containment strategies. This despite projections which place national health care spending at $1.5 trillion in the year 2000, or about $5500 annually for every man, woman, and child in America. In my judgment, this is because key provider groups lobbied hard against "their ox being gored." The result was a stampede away from cost containment.

If our Commission can't take on the special interests, how do we expect the Congress, with several hundred more opinions to juggle, to reach consensus? The inevitable result will be to hand this hot potato to the federal bureaucracy so we can blame them for either doing nothing, doing it wrong, or making decisions that are driven by annual budget pressures.

On the state level, however, we have seen a number of notable examples of innovative cost controls. Hospital budgeting and managed care initiatives are two examples that come most immediately to mind as far as what should be controlled locally.

The Chairman's proposal for access also contradicts what we know to be the public's preference. Opinion polls consistently find the public in favor of state, local, and private sector management of both financing and service delivery systems, with the federal role kept to a bare minimum.

One of the reasons the public is profoundly skeptical of a plan with a federal "top-down" policy is exemplified by the Chairman's plan to impose a national tax based on a uniform percentage of payroll for all employers who fail to provide health insurance coverage. The inequity here is clear: a uniform penalty assumes a uniform incentive to either play or pay. But the incentive to "pay out" the tax will obviously vary depending on the percentage of an employer's payroll that actually goes to cover health care costs. This, in turn, will vary enormously based on such factors as local costs of health care, demographics of the employers covered group and other factors, some of which may be unpredictable, powerful and perverse in their effect.

THE LONG TERM CARE PORTION

Let me turn to the Commission's long term care proposal and what can be done to improve it. While I supported with reservations the Commission's recommendation in the area of long term care, I am concerned that the design of the program will perpetuate the current provider attitudes and failings of the welfare-based Medicaid delivery system. Furthermore, by splitting health care responsibility at the hopelessly fuzzy line between Medicare and the new federal-state long term care package, the Commission's proposal all but guarantees that beneficiaries will continue to drop through the cracks.

While correcting these flaws will be difficult, the task is not insurmountable. Moreover, this plan, in my judgment -- even though it may require a very lengthy phase-in -- can be financed -- and this promises something that we can deliver.

As I mentioned before, it is my contention that full financial responsibility for long term care benefits must rest with the federal government. We cannot and should not expect the states to continue their level of spending in this arena and pick up a hefty tab for additional acute care benefits.

I believe we need to transform the existing Medicare benefits package for community based and nursing home care into a comprehensive, national program to assure Americans of every age access to a full continuum of long term care services.

In contrast, the Chairman's proposal is essentially a Super-Medicaid plan. It is a Super-Medicaid plan because it maintains the existing federal/state involvement in financing and administration and perpetuates the problems inherent in that public welfare program.

A major problem is the very image of public assistance. Already our aged on Medicaid are the second class citizens of the nursing home industry. Too often they get the short shrift on beds, the lesser share of services, the stigma of a social burden. Senator Rockefeller's proposal does nothing to eliminate this image. I believe the plan may even exacerbate the current flaws in at least two ways.

First, states currently have no motivation to do more than the minimum mandated by law across the spectrum of long term care services. What is proposed contains neither real incentives for states to take a more innovative, integrated approach, nor, in the alternative, alleviates the financial burden on the states.

Second, it fails to integrate the new home and community based services and the expanded nursing home protections with existing Medicare coverage.[1] We thus perpetuate the image of a two-tiered system: the Cadillac federal program under Medicare; the sub-compact program through Super-Medicaid. This image will persist independent of actual equalities in coverage because the public mentality associates Medicaid with welfare.

I believe we all need to be candid about what else needs to happen in order to actually deliver the long term care that we promise. We must address the obvious fact that the facilities and personnel needed to deliver the volume of quality of care we anticipate once benefits are expanded simply do not exist at this point in time. Current shortages in geriatric nurses, nurses' aides, social workers, therapists -- to name a few -- will be magnified many times over. We need to develop a comprehensive implementation plan well beyond anything proposed or currently even contemplated by our Congressional colleagues. Our failure to do so will cause this entire benefits house to crumble for lack of a proper foundation of qualified people to deliver the services promised.

---

[1] I have included, as an addendum, a recently published article setting forth recommendations to overhaul the Medicare program.

ON THE ABSENCE OF FINANCING

My last point perhaps should have been my first. One question that needs to be answered is why a Commission composed of Congress' smartest and most knowledgeable health care experts has settled on an overall approach promising acute care services that cannot be delivered. The answer lies in the Commission's unwillingness to meet the second major goal we adopted, namely how to "raise the financing required." Indeed we have failed completely to even address, in the most general way, the most desirable sources of financing -- particularly the $43 billion of federal financing required for the long term care plan. By failing to discuss how revenues will be raised to finance these expanded benefits, the Commission waves the magic wand of reform without the mighty genie of financing locked up in a bottle.

In addition to working to improve the Commission's long term care plan, it is my intention to pursue my alternative acute care access plan. I believe strongly in the mandate of our Commission. I subscribe to our commitment to assure all Americans access to health care coverage that allows them to obtain necessary care and assures them adequate financial protection. Such coverage should:

- be affordable to all Americans of all incomes;
- promote quality of care; and

- o be supplemented or modified, where necessary (in "undeserved" areas or for special population groups) by special programs to assure that service is accessible.

Our mission is an urgent and compelling one and I will continue to work to this end with my colleagues and all who share our concerns.

Overhauling Medicare

By U.S. Senator John Heinz

A proposed overhaul of Medicare recognizes social changes and could lead to more rational reimbursement for hospitals.

Once heralded as the archangel of health-policy reform, Medicare today has fallen in both public perception and actual protections to a much less lofty status. Indeed, 25 years after Medicare's enactment, the problems this program was designed to correct have in many ways intensified.

Medicare, which covers more than 95 percent of people over age 65, does not effectively meet the health-care needs of older Americans. For example, coverage has not kept pace with rising expenditures, resulting in dramatic increases in out-of-pocket spending for our elderly population—exactly what Medicare was intended to eliminate. The average annual expenditure for Medicare beneficiaries in 1970 was $331; today, the average is more than $3,000. What was intended as a safety net has become a complicated and cumbersome program for both seniors and their families.

Major shortcomings of the Medicare program were exposed when Congress rolled back the rug on the Medicare Catastrophic Coverage Act (MCCA). That legislation prompted one of the most heated battles over health-insurance benefits for the elderly that Congress has seen since passage of the original Medicare legislation.

This article examines the implications of the MCCA experience for future health policy under Medicare, describes how I believe we should change the program to better meet the needs of beneficiaries, and notes how such changes might affect hospitals and other providers.

In passing the catastrophic coverage act, Congress sought to protect older Americans against financial ruin in the form of out-of-pocket expenses for extended acute medical care. President Reagan identified the goal of this legislation as the removal of "a financial specter facing our older Americans: the fear of an illness so expensive that it can result in having to make an intolerable choice between bankruptcy and death...."

But President Reagan also identified the Achilles heel of the proposal: "This new program will be paid for by those who are covered by its services.... So, we must control the costs of the new benefits [respite care and prescription drugs], or we'll harm the very people we're trying to help."

As it turned out, the president was correct. So severely did the government's number gurus underestimate MCCA costs that reestimates became a weekly—even daily—occurrence in the months following enactment. The postpartum revisions of the needed

---

Senator John Heinz, R-Pa., is a member of the Senate Finance Committee and is ranking member of the Senate Special Committee on Aging. He wishes to thank Jeffrey R. Lewis, Republican staff director of the aging committee, and Isabelle Claxton of the committee staff for their assistance in preparing this article.

financial outlays pitted senior against senior and the Congress against its collective constituencies. A frequently heard objection from beneficiaries was that the benefits duplicated existing coverage and did little to address the real need—coverage for long-term nursing-home expenses. Further fueling the revolt was what must be viewed as flagrant campaigns of misinformation by some organizations and insurers whose goals were either to raise more money for themselves or to increase their "Medigap" sales.[1]

So with the spring thaws of 1989 came a literal flood of mail, each letter or petition urging Congress to undo what it had done the previous fall. In December 1989, just 18 months after its passage, Congress did repeal the single most significant addition to the Medicare program since its inception. Ironically, the retirees who favored repeal must now stand by and watch costs rise for their Medigap policies—rise to a much higher amount than they would have paid under MCCA, and for substantially less coverage. Many among those who advocated the repeal of MCCA now realize they made the wrong decision, in large measure because they had neither the best nor the most accurate information.

The postscript to the Medicare catastrophic law leaves Congress with the difficult decision of how best to proceed in the wake of repeal. Among the critical questions with which we must grapple are: Is passage of another Medicare bill possible if it does not include some kind of assistance for nursing-home costs? What kinds of benefit expansions should be pursued? Should incremental changes be pursued or should the Medicare program undertake comprehensive reform?

Two questions with which care providers must contend are: What are the realistic chances of a significant change in Medicare? What would the effects be on my organization?

Overhaul vs. caution. The Medicare program today simply does not meet the changing health and social needs of our aging population, with more than 32 million persons age 65 and over. In fact, the program can never keep pace if it continues to focus strictly on acute-care benefits. Medicare must be designed to rehabilitate—not to be a program that only promotes prevention or wellness.

Today, seniors and children of elderly parents are confronted with health-care problems that require non-traditional solutions, including homemaker services, adult foster and day care, and respite-care services for caregivers. Although minor changes have occurred within the Medicare program, they have not gone far enough to address these special requirements.

Seniors and their children are confronted with problems that require non-traditional solutions.

A particularly striking example of the blind spots in current Medicare coverage pertains to Alzheimer's disease. It is the fourth leading cause of death for older Americans. One tenth of persons over age 65 may be afflicted with Alzheimer's, while 47 percent of persons over age 85 have the disease. Families caring for the Alzheimer's patient at home find no relief in Medicare. For example, by limiting home health benefits to individuals who are "homebound," Medicare severely limits the number of Alzheimer's patients who can qualify.

A further illustration of Medicare's shortfalls lies in the benefits that were repealed as part of MCCA. Specifically, MCCA included coverage for respite-care services to assist families with the daily burden of care for someone with a debilitating or chronic disease condition. Though the respite-care benefit was triggered only after the beneficiary first met a $1,740 deductible, it presented a "foot in the door" as a means of helping families continue to care for a spouse or parent without having to resort to institutionalization. Although small in terms of the number of people it would have actually helped, this change, in my opinion, represented one of the most progressive additions to Medicare law since hospice services.

When Congress repealed MCCA, we turned back the clock to a Medicare program severely limited in benefits that assist the aged to remain independent. For Congress now, the challenge is how to structure changes in Medicare necessary to address the evolving requirements of the beneficiary population, while balancing that objective with political and financial realities.

I believe we have reached the point where, although incremental change is certainly more realistic, it is no longer appropriate. It is time to address the fundamental problems contained in Medicare—with respect to both beneficiaries and providers. In this regard, I want to focus on beneficiary changes that I believe are necessary.

We need to redefine the objective of Medicare.

Four proposals. First and foremost, we need to add a long-term care component that includes both home- and community-based care as well as "real" nursing-home coverage for persons of *all* ages. While this represents a significant departure from Medicare's current design, this change is vitally necessary.

It is no secret that the states would be crippled financially if they had to pay the Medicaid tab for both acute and long-term care. I believe that Congress should more equitably balance the costs by giving states the predominant fiscal responsibility for acute-care services for persons under age 65 who, for whatever reason, are without health-insurance coverage. Sole fiscal responsibility for all long-term care for people of all ages would shift to the federal government. This division of fiscal responsibility for acute and long-term care should assist state governments by reducing their fiscal burdens. At the same time, this will eliminate the politicization of the cost of such services. Such a plan ensures a more rational system and one that is easier for all to understand.

Second, in order to reduce what is now an overly complex reimbursement system, Medicare Parts A and B would be collapsed into one comprehensive acute-care program. Too many beneficiaries do not understand the nuances and idiosyncrasies of the current program and, as a result, have become extremely frustrated with Medicare.

Third, in conjunction with folding Parts A and B into one program, I feel strongly that each beneficiary should know the maximum amount he or she might have to spend in total out-of-pocket costs for medical services each year. We need to establish some form of out-of-pocket limit based on income.

Fourth, states cannot afford to pay Medicare premiums for people who are eligible for both Medicare and Medicaid. We should recognize that individuals who are economically deprived and unable to afford medical care should have to make only minimal, if any, contributions to the cost of their care. States should be exempt from having to make payments to the Medicare program for such persons. This would free additional state funds for acute-care services for the uninsured, which should lead to increased and more rational reimbursement for providers.

In sum, we need to redefine the objective of the Medicare program. The basic principle must be that no beneficiary should ever be forced into any kind of institutional setting unless absolutely necessary.

The Medicare program has not changed to reflect the changing needs of older Americans and their children. That change in needs is driven by the changing structure of the American family. In 1965, for example, most families had an adult female who remained at home, a built-in caregiver for aging parents or spouse. Twenty-five years later, this is no longer the case; in most households, both spouses work. There is no longer a full-time, adult family member to take care of an aging parent at home. Because neither Medicare nor most private health insurance reimburses for services such as adult day care or respite care, many families are forced to place an aging parent into an institutional setting.

Such changes in family structure combined with the aging of the population underscore the urgent need for the Medicare program to accommodate the profound changes in our society. Respite care and adult day care, for starters, are both necessary to help families care for an aged parent or spouse. We must be cautious, however, that federal benefits supplement, not replace, care provided by families.

Rational reimbursement. Having said this, it is important to remember that these changes, or any major changes in Medicare, will have some impact on providers. We need, therefore, to ascertain whether a more rational and easier reimbursement system can be developed to coincide with the restructuring of Medicare benefits.

For too long, Congress has been dictating provider reimbursement based solely on budget policy rather than focusing on whether the system is flawed, and if so, how best to fix it. Congress has made attempts to change the system by encouraging alternative forms of health-care delivery, changing Medicare reimbursement and, most recently, by reforming physician payment. Nevertheless, these efforts still represent piecemeal solutions to a program in need of radical overhaul.

We must begin by recognizing that a Medicare overhaul is a political nightmare. First, the hundreds of provider groups, each of which has its own best fix, can never be satisfied. Congress and the various committees of jurisdiction must not only expend the time and energy necessary to craft reform, but risk the heat associated with any reform cuts and costs.

Instead of a reform, however, we experience the incessant tinkering of a Congress determined to use the Gramm-Rudman-Hollings budget process for policy reform. Typically, as part of a spending-reduction package to meet the GRH target, Congress may, for example, recommend delaying payments to providers by anywhere from one day to one week. While this budget gimmickry results in paper savings, it can, and often does, have an adverse impact on hospitals and physicians forced to adjust to delayed payment.

Bradford Hospital in Bradford, Pa., recently wrote that the current seven-day payment lag for that facility is a $100,000 cash loss. “With our current operating cash balance at $23,000,” the hospital vice president wrote, “this type of adjustment would require us to incur short-term borrowing costs for working capital, particularly if the adjustment happened in a payroll week. There is no actual dollar savings for the government from such an adjustment....”

A Medicare overhaul is a political nightmare.

This example is only one of many, but it typifies the problems created by Congress’s efforts to reduce the deficit and underscores the need for complete overhaul.

The comprehensive reform of the Medicare program that I’ve outlined emphasizes a thoroughly restructured benefits package that recognizes changes in the structure of the American family. Such an overhaul is necessary in order to assist families, old and young, in caring for their parents or spouses in noninstitutional settings and to banish, so far as possible, the traumatic prospect of costly and unnecessary institutionalization. At the same time, such changes should eliminate some problems hospitals now face and stimulate continued evolution of hospitals’ roles. HMQ

Notes

1. Hearings of the U.S. Senate Special Committee on Aging, Jan. 8, 1990, Harrisburg, Pa., chaired by Sen. John Heinz, R-Pa.

Additional Views--Senator Edward M. Kennedy

America faces a health care crisis of unprecedented proportions. Too many Americans are uninsured and underinsured, and the number is growing every year. Too many of the elderly and their families, as well as disabled younger Americans, can not afford essential long-term care. Health care costs are too high and are rising rapidly out of control. Too many health care institutions are facing collapse.

As the Commission report and the extensive hearings conducted by the Commission make clear, the impact of this crisis on individual American citizens can be devastating. Each family affected by this crisis is a uniquely American tragedy, and the number of families at risk numbers in the tens of millions. Thirty-two million Americans have no health insurance coverage at all, and as many as 60 million more have insurance that is inadequate. Over a twenty-eight month period, sixty-three million Americans will be without coverage for a substantial amount of time. Indeed, few American families can be confident today that their insurance is adequate to prevent real financial hardships or even financial catastrophe in the event of serious illness.

The requirement of long-term care protection is equally essential. More than three million senior citizens need long-term care today. Forty per cent of today's elderly Americans will need nursing home care at some point in their lives.

Perhaps the saddest statistic of all is that fifteen million Americans annually fail to get needed health care because they cannot afford it.

Under Senator Rockefeller's leadership, a majority of this Commission has recommended major reforms to deal with this worsening crisis. These recommendations offer a sensible and long overdue means to end this tragedy.

In the case of universal health care, the Commission recommendations build on the best of our current public-private partnership to provide insurance. The proposals are moderate and reasonable and require all the parties involved--government, business, and individuals--to make a fair contribution to the solution.

In the case of long-term care, the Commission recommends a combination of social insurance and middle-income protection which is consistent with the way Medicare successfully protects senior citizens against the high cost of hospital and physician care.

Some have criticized the Commission for going too far; others say it did not go far enough. In my view, the issue is one of political will. Our failure to guarantee health care as a basic right for all Americans is unacceptable. No other industrial nation in the world, except South Africa, tolerates such an inhumane policy. The longer we wait to deal with this problem, the more difficult it will be to solve.

Enactment of comprehensive reform of our health care system should be the highest priority for the next Congress. The Pepper Commission has provided an excellent start for meeting that commitment.

MARY ROSE OAKAR
20TH DISTRICT, OHIO

WASHINGTON OFFICE:
2231 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-5871

DISTRICT OFFICE:
523 FEDERAL COURT BUILDING
215 SUPERIOR AVENUE
CLEVELAND, OH 44114-1281
(216) 522-4927

Congress of the United States
House of Representatives
Washington, DC 20515

COMMITTEES
BANKING, FINANCE AND URBAN AFFAIRS
CHAIR, SUBCOMMITTEE ON ECONOMIC STABILIZATION
POST OFFICE AND CIVIL SERVICE
SELECT COMMITTEE ON AGING
CHAIR, TASK FORCE ON SOCIAL SECURITY AND WOMEN
COMMITTEE ON HOUSE ADMINISTRATION
CHAIR, SUBCOMMITTEE ON PERSONNEL AND POLICE
JOINT COMMITTEE ON THE LIBRARY
WHIP AT LARGE

August 2, 1990

The Honorable Jay Rockefeller
Chairman
The Pepper Commission
140 Cannon HOB
Washington, DC 20515

Dear Mr. Chairman:

Enclosed are my additional views regarding the activities and recommendations of the Pepper Commission. I ask that you include them with the statements of the other Commissioners into the final report of the Commission.

Serving on the historic Pepper Commission with you and the other Commissioners has been a distinct pleasure. I am confident our efforts will serve as an effective starting point for solving America's health care crisis. It remains my great hope that we can rapidly realize Claude Pepper's last great dream--providing access to high-quality health care services for every American. The Commission's recommendations should help us begin to accomplish that goal.

Congratulations on a job well done!

With warm personal regards, I remain,

Sincerely,

Mary Rose Oakar

Mary Rose Oakar
Member of Congress

MRO:jpm

Commissioner The Honorable Mary Rose Oakar

ADDITIONAL VIEWS: THE NEED FOR UNIVERSAL CARE

The Pepper Commission is perhaps the most important health care forum convened in the last 20 years. It is the brain child of one of the nation's best known and best loved health care experts -- Claude Pepper. The late Senator Pepper, my friend and mentor, wanted the Commission to find solutions to the two major elements of our health care crisis -- a lack of access to proper medical services for 37 million Americans and the lack of long-term care for most of our citizens. Claude Pepper was a national hero and leader in the fight to provide basic health care and long-term care for all Americans for most of his distinguished career. His death early in the proceedings of the Pepper Commission was considered a tremendous loss by all. In fifty years of public service, Claude Pepper had one unfulfilled dream -- to provide universal coverage to every American.

However, in spite of the loss of Senator Pepper, the Pepper Commission succeeded. Under the able-bodied leadership of Chairman Jay Rockefeller, the Commission came to a consensus regarding both primary health care problems. This was not accomplished without a major effort on the part of the Chairman. For example, the Chairman graciously incorporated into the text of the original recommendations, 12 of the 14 proposals I offered. These improvements include the language regarding alcohol and drug abuse treatment; the provision of annual mammograms and colorectal and prostate cancer screening examinations; prevention through education to change unhealthy behaviors and lifestyles; cognitive impairment language; case management provisions sufficient to meet all needs of long-term care patients; protection against fraud and abuse for consumers of private long-term care insurance policies; and the provisions for scientific research into cures and preventions for long-term aging illnesses and breast cancer. As a result, I salute Chairman Rockefeller and the rest of the Commission for a willingness to meet the requests and needs of individual commissioners, such as myself.

During its virtually endless briefings and discussions, the Commission learned a great deal about the size and scope of our nation's health care problems. For example, thirty-seven million Americans are without health insurance of any kind and perhaps as many as 40 million Americans are underinsured. Of the uninsured individuals, one third, or 12 million are children under the age of 18. The area surrounding my home town of greater Cleveland, Ohio has similar difficulties; over 213,000 people do not have health insurance in the four county area making up northeast Ohio. In addition, the trend, nationally as well as locally in Cleveland, is that uninsurance is increasing. In my home area, the rate of uninsurance has increased from 7.9% of the population in 1980 to 11.4% of the total population in 1987 -- a 44.3% increase in just seven years. Moreover, one of the more frustrating aspects of our uninsurance problem is that 88% of the uninsured come from hard working, independent-minded families.

Another dimension of the problem is the fact that the United States currently spends almost 12% of its gross national product on health care services. This is a much greater amount than any other nation. For example, Canada spends about 8.5% of its GNP on health care while West Germany and Japan respectively spend approximately 8.1% and 6.7% of their GNPs on health care. Furthermore, as a trend, our nation continues to pay for much greater annual cost increases for health care than any other western nation. One of the obvious implications of this data is that if we lowered our spending to the level of our economic competitors, Japan and West Germany, we could invest the saved money into other pressing concerns, such as education, infrastructure development, scientific research and development, and environmental needs which would make our nation more internationally competitive. Our current health care system is helping to place us in an untenable economic situation. We Americans pay more and get less. We are the only industrialized nation, except South Africa, that does not offer universal coverage and long-term care for its citizens.

Long-term care is the other major health care problem faced by the Pepper Commission. The lack of long-term care coverage, perhaps more than the problem of uninsurance, concerns Americans greatly. Approximately 9 million Americans need long-term care; many of these people are children who are accident victims or who are fighting a disease. Further evidence of the problem is that demographic trends indicate that the 85-and-older age group is the fastest growing age group in our country; most members of this group are frail elderly women. By the year 2040, elderly persons will represent 22% of the nation's population, as opposed to 12% today. These facts have not been lost on the American people. In fact, most Americans realize that long-term care is an intergenerational problem since middle aged Americans may have to pay for the health care expenses of their grandparents, parents, themselves and their children. This is a frightening situation for our middle- and moderate-income citizens.

In response to these pressing problems, the Pepper Commission responded with many positive recommendations. I voted to support both major sections of the recommendations because of my belief that the recommendations take a halting but very significant step toward solving our severe health care crisis. In particular, I strongly support the provisions which provide 1.) universal access to health care for all Americans, regardless of income level; 2.) a new social insurance program with income protection for long-term care; 3.) coverage for preventive measures, such as mammograms, colorectal and prostate screening procedures, prenatal care, well-baby care, and a vigorous program of scientific research into the prevention of a wide array of aging diseases and disabilities, and; 4.) extensive coverage for alcoholism and drug abuse prevention and treatment services.

However, since the Pepper Commission recommendations are a compromise set of recommendations, by definition, they represent a middle path solution. Because of the extreme crisis nature of our health care problem and the inherent weaknesses of simply modifying the current failing system, I believe the ultimate solution to our health care crisis requires a more fundamental transformation of our health care system. I believe a universal access, national health care system should be established and that it should be based on the following:

* Nationwide polls prove that Americans consistently support the creation of a universal national health care system which provides health care as a right for all our citizens. In contrast, the Pepper Commission proposal relies on an adjustment to our current employer-based system -- the system which is failing us so miserably today. Instead, I firmly believe we should enact a universal health care system now, just as the American people demand;

* The Pepper Commission recommendations do not emphasize enough the need to contain costs. This is ignoring perhaps the most important aspect of our health care crisis -- rapid cost escalations. As an answer to this problem, we need to enact a national health care system with a single payer, or, preferably, a state government-administered system which can exert much more effective cost containment powers;

* Polls also show that Americans want a state-based health care system -- similar to Canada's health care program -- instead of a federally-based system like the new public insurance plan in this report. Americans believe that bringing health care administration closer to home makes the system more familiar and friendly and that it allows greater control over benefits and expenditures. A state-based system also allows greater flexibility over the design of health care plans tailored to meet the special needs of local, state and regional areas;

* There is no consumer choice within the new public insurance plan. Instead, it is based on a "one size fits all" benefits package. Americans prefer and demand choice over their health care plans. We need a state-based, universal access national health insurance program which

will allow Americans to choose the coverage plan they want, yet one that will allow the participation of providers, insurers and others;

* The Commission recommendations offer only three months of nursing home coverage, in spite of the fact that most nursing home stays last at least 4 months. This is clearly inadequate coverage. I offered an amendment to the Commission's plan to increase coverage from three months to six months, but unfortunately my amendment was not accepted. However, the new long-term care plan should offer at least 6 months of nursing home coverage without the necessity of a spend down of personal assets;

* The Commission's long-term care plan is based on a 3-or-more activities of daily living (ADL) requirement instead of the more realistic and humane 2-or-more ADL condition. The Commission's 3-or-more ADL limitation means that approximately 250,000 needy and disabled Americans will not qualify for coverage. I offered an amendment to change this unreasonable part of the proposal to 2-or-more-ADLs, but my proposal was not accepted. I strongly believe this provision of the Commission's plan should be changed.

In summary, the severity of the health care problems we face ultimately requires a much more aggressive answer than the compromising recommendations made by the Pepper Commission. Specifically, we need to move now to create a universal health care system which offers state government administration, federal oversight, consumer choice, a strong concentration on prevention, and competition among providers.

I have incorporated all of the improvements to the Pepper Commission recommendations mentioned above into a bill, H.R. 4253. This legislation offers a complete restructuring of our health care system by offering universal access to a comprehensive set of acute care and long-term care benefits to every citizen of our nation. The federal government provides basic oversight of the program, quality assurance guidance, and partial funding. The state governments are charged with day-to-day administration and must make up the rest of the funding of the program. Special care has been taken to allow consumer and group participation in the formulation and offering of state-qualified health care plans from which consumers can choose. I am convinced that because of the state administrative features of my bill, we will more forcefully and effectively control unreasonable cost increases.

Effective cost containment should form a central feature of any health care legislation. During the Commission's mark-up session, I offered my plan as a substitute, but by a 6 to 9 vote the amendment was not accepted. However, I was heartened by the support of six Commissioners who voted for my substitute amendment.

Moreover, H.R. 4253 offers an excellent long-term care plan which not only provides six months of nursing home coverage and access to benefits based on a two-or-more activity of daily living (ADL) qualification, it also provides for the option to "purchase" extended nursing home insurance through the federal government. Furthermore, like the Pepper Commission plan, the long-term care program in H.R. 4253 is case managed which ensures a high standard of quality care. I have also included a hospice care program for the terminally ill and coverage for skilled nursing facility care. In addition, the long-term care benefits are available for people of all ages.

Another major feature of H.R. 4253 is the strong emphasis placed on prevention programs and scientific research for the prevention and cures of diseases. Since my provisions regarding these subjects were accepted virtually unchanged by the commission, my bill offers a similarly extensive program of coverage for preventive care services such as mammograms, pap smears, colorectal and prostate cancer screening exams, prenatal care, well baby care from the moment of birth and well child care through age 22, basic immunizations, and nutrition counseling. I strongly believe preventive care is the wave of the future, not only for preventing pain and suffering or enhancing the quality of life, but for purposes of saving lives and money. This is a common sense approach to health care management.

My bill also incorporates provisions regarding scientific research and development of preventions and cures for a wide variety of diseases. Not only does H.R. 4253 include similar proposals to aggressively fund research into aging diseases to those I offered and were installed into the Pepper Commission plan, it also provides more research into diseases which affect minority populations and women. Research money is provided for studies to prevent and cure sickle cell anemia, hypertension, infant mortality, aids and breast cancer. This kind of far-sighted research is needed to save money and lives.

Additional preventive care in my bill can be found in the form of the National Health Objectives provisions. This section of the bill contains block grants for state-based prevention programs based on a report issued by the Department of Health and Human Services which urges attainment of 21 National Health Objectives (e.g. cessation of tobacco use, reduction of alcohol use, improve nutrition, increase physical activity, prevent and control HIV infection, etc). The intention of this legislation is to educate the public about and work toward the prevention of lifestyle behaviors and other health factors that contribute to larger public health care problems. It has been estimated that if we achieved only a 1% reduction in the societal costs associated with 12 of the 21 health objectives, the return on our investment for the first year would equal 10-to-one. In other words, we would achieve a savings of over $6 billion for the $600 million invested by the bill. I was disappointed that several of the specifics of this proposal were not accepted by the Commission.

Furthermore, as a positive reaction to the continuing and growing national problem of alcoholism and drug abuse, my bill provides for an effective continuum of care for the management of addictive diseases. In particular, H.R. 4253 is intended to provide special acute care services such as intervention, assessment diagnosis, referral, medical detoxification, post-detoxification primary treatment, aftercare, and individual and group counseling by certified providers. My bill also intends to cover day treatment, DUI intervention programs, outpatient care, and relapse prevention. Special long-term care services are intended to cover 30-60-90 day certified halfway houses, and 90-120 day certified three-quarter way houses. Of special concern is the need to cover populations generally requiring long-term care such as pregnant, addicted women and their children, addicted adolescents, and the addicted homeless who now comprise 70% of the homeless population. We must help our people defeat the scourge of alcoholism and drug abuse through the kind of humane and cost-effective treatment services proposed in my bill.

According to Pepper Commission estimates of a federally-based national health care system, implementing a single payer national health plan would cost the federal government approximately $224 billion in additional expenditures, with net new costs to society of $8 billion (versus the more expensive $12 billion in new costs to society of the Pepper Commission recommendations). However, keep in mind that employers, employees and others already pay approximately $190-$200 billion per year in private health care insurance premiums. Also remember that a national health care system would save at least $24 billion per year in the reduction of paper work, and that it would provide additional savings by creating a national "health care data base" which would be scrutinized for further cost savings. Furthermore, my bill is based on a split in state and federal funding contributions which , relative to the Pepper Commission estimates, will greatly reduce the amount of new expenditures that will have to be made by the federal government.

If all of these factors are taken into account, national health insurance not only becomes cost effective, I am convinced it will save our nation billions of dollars each year in health care expenses. Americans spend approximately $661 billion for health care, with much of this expense borne out-of-pocket, and still 70 million Americans are uninsured or underinsured.

In a further effort to contain costs, my bill would implement a series of tough and effective cost control measures. For example, it would require federal approval of state health budgets which reflect total health care expenditures for the entire state; state governments must approve global hospital budgets; state governments must negotiate with qualified providers for fair and reasonable reimbursement; the states would approve capital and high-technology equipment expenditures of hospitals and physicians, and; as I have stressed previously, my bill emphasizes cost saving preventive health care services. Taken collectively, I am convinced these services would produce substantial savings over the current health care system.

In closing, I am proud to have served as a Commissioner on the Pepper Commission. I believe the Commission's plan is an excellent step toward the ultimate resolution of our enormous health care problems. However, I also believe the United States must accept the inherent limitations of our current system and the Pepper Commission recommendations and enact national health care legislation providing universal access to a comprehensive array of services, a complete set of long-term care services for citizens of all ages, a strong emphasis on prevention, and significant funding in scientific research for the prevention and cure of a wide range of diseases. Creating a national health care system would not only be the fairest and most effective way to manage our health care system, it also would go a long way toward meeting the true health care needs of our people.

Throughout my service to Congress, I have believed that access to decent health care is a right of all Americans and, therefore an exceptionally important anchor issue. Without access to proper health care, our people cannot succeed and thrive. Therefore, we should do all we can to assure access to health care and long-term care services for people of all ages. We will do well not to forget the views offered by one of our nations's great leaders, Thomas Jefferson:

> "With your talents and industry, with science, and that stedfast honesty which eternally pursues right, regardless of consequences, you may promise yourself everything - but health, without which there is no happiness. An attention to health then should take place of every other object. The time necessary to secure this by active exercises, should be devoted to it in preference to every other pursuit."

David Pryor

Senator David Pryor's Pepper Commission Statement

Before I comment on the Pepper Commission's report, I would first like to pay tribute to the Commission's founder, first chairman, namesake and inspiration, Claude Pepper. Without Senator Pepper's unbridled diligence and commitment to meeting the many health care needs of this nation, we never would have had a Commission in the first place.

Although Claude Pepper's untimely death made it impossible for him to lead us through our deliberations, I believe we were all inspired by our personal memories of his decades of leadership in the health care arena. There is no question in my mind that his ideals will continue to be an influence on the Congress and the Administration for decades to come.

The absence of Claude Pepper made it imperative that we choose a new Chairman who had the tenacity and skill to forge an agreement that could be supported by a majority of members. In unanimously voting in Jay Rockefeller, I am convinced we chose the only man who could accomplish this daunting task. Jay's resolute determination to meet the Commission's charge, his refusal to never give up on this Commission or any of its members, and his success in developing proposals that could be supported by a bi-partisan majority are nothing short of awe-inspiring. It was an honor and a pleasure to serve under a man whose complete dedication to addressing our nation's health care needs is unmatched.

It is not necessary to repeat the litany of facts and figures that our report so well documents. Needless to say, however, the problems that confront our health care system are overwhelming.

We know that over 32 million Americans (430,000 Arkansans) have no insurance and that people without insurance delay or go without care. We know that as many as 9 million more people need some form of long-term care and that many of these people, in order to get needed care, are forced to impoverish themselves to qualify for any assistance. But what do these statistics and facts really mean?

The Pepper Commission helped us to understand the problems by attaching real human faces to them. None of us can forget the grandmother who needed long term home care, but the family could not afford it or provide it themselves. The whole family suffered when the grandmother was forced to go into a nursing home to get the only help that was available.

We all felt anguish for the mother who had no insurance and was denied treatment for her child, and for the father who had to quit his job so that his sick child would be eligible for medical assistance. Stories like these are what my constituents and I understand.

Through seeing our health insurance premiums increase at double-digit rates, we are beginning to understand that those of us fortunate enough to have insurance are paying higher premiums to cover not only us but those who do not have insurance as well. We better comprehend the scope of the problem when we see how rising health care costs and discriminatory sales tactics by insurance companies are making it harder and harder for employers to afford the insurance they want for their employees.

We understand the problem when we see our local hospitals forced to the brink of closure because too many admissions have no insurance at all. And, in the greatest nation in the world, we know there is a major problem when we see health care rationed not on the basis of need but on the basis of access to money. These and many other serious problems are symptoms of a diseased health care system that is disintegrating before our very eyes.

Yet, despite these unacceptable shortcomings, few people would dispute that we enjoy the benefit of the best medical care in the world. The only problem is that the price of admission is turning too many people away from the health insurance ticket office.

The question is: What are we going to do about the health care crises we face? In every Pepper Commission meeting there was unanimous agreement about the scope and degree of the problem. Where we faced disagreement, of course, was in how to address the problem. That a diverse group of policymakers could not unanimously agree on everything is not surprising. That such a group could develop a bipartisan majority on how to proceed certainly was a major accomplishment and is a tribute to the Commission's Chairman.

The package of recommendations that emerged from this Commission is not perfect. No one ever made such a claim. I doubt that there is one Commission member who feels totally comfortable with every recommendation or omission.

Because almost every private health insurance plan and every State Medicaid program voluntarily offers prescription drug coverage, and because 7 out of the top 10 drug classes used by the elderly are for chronic, long-term conditions, I personally believe that a prescription drug benefit should be a component of any basic health and long-term care coverage package. I was therefore disappointed we did not include a prescription drug benefit.

Along those lines, my ideal package of benefits for both basic health and long-term care -- and how they would be phased-in -- would probably vary somewhat from our final recommendations. In addition, I would like to have seen more emphasis on health care cost containment, including the issues of malpractice reform and health care fraud and abuse. And, among other things, I believe that a trigger mechanism that requires small businesses to provide health care benefits should more adequately take into account the degree to which we as a nation are successful in controlling skyrocketing medical inflation.

Having said this, I fully realized when I became a member of the Commission that a package that emerged out of our deliberations had to represent, to the extent possible, a consensus package. Due to inevitable differences of opinion and time constraints, there were compromises that had to be made along the way.

What emerged, however, was what I believe to be a pragmatic, well thought out series of recommendations. By phasing in the basic health care recommendations, the Commission recognized that major, structural reforms take time to be properly implemented and financed. The report includes essential provisions to control costs and assure quality care. It makes recommendations that illustrate a sensitivity to the concerns and needs of small business.

The phased in long-term care recommendations are similarly pragmatic. They recognize the desperate need to assure assistance with home care for all disabled Americans. They provide assistance with nursing home care before people become impoverished and they encourage the development of private long-term care insurance. As Chairman of the Senate Special Committee on Aging, I was particularly pleased to see the overwhelming vote in support of addressing the multi-generational, family issue of long-term care.

The Pepper Commission recommendations therefore represent a sound, sensible approach to dealing with the nation's health care challenge. To enact these or any other major health care reforms into law, however, we must realize that such necessary changes will not come without pain or commitment from all participating parties. Significant financial and intellectual contributions will be required from, among others, health care providers and insurers; employers, employees and their representatives; Federal, State and local governments; and even the users of health care.

The multi-billion dollar question is: are we all willing and able to make the needed sacrifices to meet the health care challenge facing us? If anyone of us is not, we simply cannot and will not move forward. If so, there remains one major player who will be needed to assure success. That person is, of course, President George Bush. No major restructuring can be achieved until and unless the President pushes the health care needs facing the nation up near the top of his agenda. Unfortunately, he has yet to illustrate his willingness to do this. It is my hope that the release of this important report will encourage the President to giving our nation's numerous health care needs the attention they deserve.

The 18-month voyage of the Pepper Commission could never have reached its final destination without the dedicated commitment of the Chairman and 14 other members, their staffs and, in particular, the Pepper Commission staff. They all put in monumental amounts of hours into assuring that the Commission would be the success that it has been and will be. I commend them all for their excellent work.

In particular, I would like to recognize the Pepper Commission staff, headed by Judy Feder and Ed Howard. I have no doubt that these two fine individuals had no idea what they were getting themselves into when they stepped into their positions. I also have no doubt we could not have arrived to this point without them. The staff that these two individuals were smart enough to hire represent an excellent example of their leadership. Rarely have I have seen such a group of extraordinarily committed and productive individuals.

I also would like to mention three specific staff persons from Senator Rockefeller's personal office who made invaluable contributions to the Pepper Commission. Like their boss, Mary Ella Payne, Karen Pollitz and Tamera Stanton are among the most talented health policy experts and advocates in the Senate. We are indeed fortunate to have the four of them on Capitol Hill.

The place in history that the Pepper Commission will take is still an unknown. Many skeptics inside the Washington, D.C. beltway have already written off its recommendations and have concluded it will be relegated to the long list of reports gathering dust in bookshelves around the country. I predict that these people will be proven wrong.

I believe the Pepper Commission's report will serve as the bricks and mortar of the health care reform building that we as a nation will be eventually forced to construct. It is clear to me that is just a matter of time before we start breaking ground. I therefore would strongly advise everyone not to ignore this very useful blueprint that Jay Rockefeller and the Pepper Commission have designed.

THE HONORABLE PETE STARK

DISSENTING VIEWS
FINAL REPORT OF THE PEPPER COMMISSION
AUGUST 10, 1990

The Commission has done an outstanding job defining the scope of problems in the areas of health and long-term care coverage. I commend Chairman Rockefeller for his hard and constructive work to shape a position on these contentious issues which a majority of the Commission could support.

The Commission was charged to design and finance a program to protect every citizen against the high costs of health and long-term care. Such a program was to be universal and cover all Americans. It was to be comprehensive and cover all basic health and long-term care services. The proposal for coverage was to be balanced with specific financing proposals. The financing proposals were to raise revenues sufficient to support the costs of the program.

In its early deliberations, the Pepper Commission agreed unanimously to specific goals which I strongly support to meet the basic objectives mandated by statute when the Commission was established. These goals were adopted to meet the basic objectives mandated by statute.

The Commission failed to meet each of these goals. Therefore, I am unable to support the final report. In this statement I outline my objections and offer an alternative which responds fully to the Commission's statutory mandate and specific goals.

CONCERNS WITH THE PEPPER COMMISSION RECOMMENDATIONS

Comprehensive Health Insurance

To expand health insurance coverage, the Pepper Commission recommendations would build upon the employment based system through mandates on employers, or the "pay or play" approach.

I have several concerns with the "pay or play" approach.

First, employment-based approaches have not and cannot assure that every American gets health insurance coverage. Only a single-payer plan under public auspices can assure universal access for every American to a basic level of health benefits at an affordable price.

Mandating employers to provide health insurance sounds like a good idea in theory, but faces several practical difficulties in implementation, particularly with respect to part-time and seasonal workers and workers who change jobs several times in a year, as well as changing family patterns.

In all probability, part-time and seasonal workers would not get the health insurance they need and would continue to be excluded with an employment-based approach. Recent research indicates that the uninsured are far more likely than the insured to change jobs, be employed by more than one employer, or be unemployed for some period during the year.

It is not clear how an employer-based system will deal with these individuals. For example, will these workers be charged an additional deductible every time they are forced to change jobs in a year? Will a seasonal worker be covered during non-working periods? What about children and/or dependent spouses? A public plan is the only way to provide coverage to these workers.

Family patterns are changing rapidly in the U.S. with increasing numbers of single parents and multi-marriage families. These changing patterns create equity problems with employer-based systems and often leave children or spouses without the coverage needed. What is a fair way to determine which parent's employer would pay for the children's coverage? Would the plan work after a divorce? Again, only a public plan can assure that all children are covered and that payment on their behalf is shared equitably.

A second major concern is that the Pepper Commission plan fails to deal responsibly with the problem of making health insurance affordable to small businesses. A single national plan is the only realistic way to make health insurance affordable to small employers.

A national plan pools high risks with low risks, thus assuring that no employer is penalized simply because a given employee suffers from a chronic malady which requires expensive medical treatment. This pooling of risk, coupled with strong cost containment, will do far more to make insurance affordable to small employers than will the phase-in approach contained in the Pepper Commission proposals.

Third, the Pepper Commission's employment-based plan fails to include any realistic proposals for health care cost containment.

Proposals that mandate the purchase of private health insurance by employers, as proposed by the Pepper Commission, are far less likely than public approaches to exert sufficient control over health care costs.

Through the use of a single national plan, operated by the Federal government, it is possible to build upon the fiscal discipline that we have already achieved in Medicare hospital payments and as we expect to achieve in Medicare physician benefits, through the recently enacted physician payment reforms. An employer mandate continues the ineffective patchwork approach to controlling costs which characterizes the current system.

Long-Term Care

I am also unable to support the final recommendations of the Pepper Commission in the area of long-term care.

My reluctance to support the recommendations pertaining to long-term care is based upon two concerns.

First, the Pepper Commission recommended public coverage of the first three months in a nursing home and leaves the beneficiary at risk for any long-term confinement. The fact that seniors are far more concerned with the catastrophic cost of lengthy stays in nursing homes than they are with costs of the first few months is attested to by almost every major senior advocacy organization. About 20 to 25 percent of the elderly will spend more than a year in a nursing home. One in five nursing home users will exceed five years of nursing home care over the course of their lifetime. In fact, those who stay in a nursing home for over six months end up having an average stay that exceeds two and a half years. This could mean more than $75,000 in out-of-pocket costs.

The prospect of having to spend $75,000 for a family member with Alzheimer's Disease or other chronic illnesses is the real fear that is driving support for a new long-term care program. The first few months in a nursing home -- referred to as the "front end" and amounting to $6,000 or even $9,000 -- is a relatively small concern by comparison. It is, moreover, relatively easy to cover with personal savings or private insurance.

A second concern with the Pepper Commission recommendations is that the bulk of nursing home dollars are directed to a means-tested nursing home program.

Middle income Americans who have worked and saved throughout their lives should not be forced onto welfare before receiving nursing home benefits. The Pepper Commission proposal is means-tested; nursing home benefits after the first few months are available only to those who meet an income and asset test.

Financing of the Pepper Commission Proposals

On the issue of financing I believe the Pepper Commission's recommendations are absolutely non-responsive. There are no specific financing proposals. My fellow commissioners who support this section of the report must believe in a "health care fairy" who will place vouchers under beneficiaries' pillows.

In my view, it is unrealistic to put forward a health care plan without simultaneously suggesting specific financing options. We cannot and will not have comprehensive health and long-term care benefits unless and until sufficient revenues are raised.

MEDIPLAN: AN ALTERNATIVE APPROACH

On July 18, 1990, I introduced H.R. 5300, the MediPlan Act of 1990. While the various segments of my proposal lost on votes by the commissioners, no options have emerged that respond directly to the Commission's mandate.

MediPlan is comprehensive. It provides health insurance and long-term care services to all Americans.

It is self-financing and financed in a progressive manner. It is budget neutral and contains proven cost containment and quality control features.

With the enactment of MediPlan, health and long-term care services will become a basic right of all Americans. All residents of the United States would be enrolled in a Medicare-like plan and thereby eligible for health benefits. All chronically ill individuals, regardless of age or income, would be eligible for comprehensive long-term care services.

Under H.R. 5300, every American, rich or poor, including the 37 million uninsured, would have basic health care benefits. Low-income persons would receive additional, essential benefits, such as prescription drug coverage. MediPlan would also offer relief to chronically ill individuals of all ages faced with the crippling costs of long-term care.

It is extremely important to offer a comprehensive approach to health care reform. The need for long- term care services is as vital and pressing a problem as the need for health insurance protection. MediPlan is a model program to provide health insurance and long-term care coverage to all Americans.

MediPlan is based upon four fundamental principles:

- MediPlan would entitle all residents of the United States to comprehensive health and long-term care services;
- MediPlan would assure that health and long-term care services are affordable to all Americans and are financed according to every individual's ability to pay;
- MediPlan would recognize the providers' right to reasonable payment for services provided; and
- MediPlan would be a comprehensive plan; it would be self-financing and budget neutral.

The proposed legislation raises the revenue necessary to cover its cost. Through a combination of employer and employee-paid premiums plus a new tax on gross income, MediPlan provides a blueprint for financing comprehensive health and long-term care benefits.

Health Insurance Benefits Under MediPlan

Under MediPlan, every American not eligible for Medicare would be enrolled in the new national health program for basic health benefits. The plan would build upon the popular and proven Medicare program and assure every American access to high quality medical care at a reasonable cost. Basic benefits would be based on the model of Medicare with minor modifications.

Because MediPlan would cover every American, there would no longer be a need for the Medicaid program to cover acute care needs. For low income persons, MediPlan would provide additional benefits, such as prescription drug coverage. Low income determination would be based on tax return information. There would be no more two-tiered or means-tested programs.

To meet the objective of providing universal health insurance coverage to all Americans, all residents, other than Medicare beneficiaries, would be eligible for MediPlan benefits, including:

- Medicare benefits with a single deductible of $500 and an added out-of-pocket limit per person of $2,500;
- Children's benefits, including well-child care and preventive care recommended by American Academy of Pediatrics without co-payments or deductibles;

- Low-income benefits, including unlimited hospital care, outpatient prescription drugs, eyeglasses and hearing aids and no co-payments or deductibles;

- Pregnancy-related services, such as pre-natal care, inpatient labor and delivery, postnatal care, and postnatal family planning services based upon the recommendations of the American College of Obstetrics and Gynecology, without co-payments of deductibles.

Employers currently providing health insurance to employees would be required to continue providing benefits in excess of the MediPlan basic benefits, to current employees and dependents.

Reimbursement to providers would be based upon Medicare's reimbursement systems, including the Prospective Payment System for hospitals and the Resource-Based Relative Scale (RB RVS) subject to volume performance standards for physician services.

It is important to note the effects of this proposal on the private health insurance industry. They will obviously be preempted from the basic individual and group health business. The industry record has been poor. Private companies are -- each year -- decreasing their exposure to risk, reducing coverage and failing to contain costs.

There is an opportunity created for these companies to provide supplemental coverage as they do now for Medicare beneficiaries . Health insurance officials have estimated that profit margins are substantially greater for "medigap" policies than for individual and group health. This program will create a market of over 100 million new customers in a more profitable line of business.

To finance the basic health benefits, every person with income above the poverty line would pay the MediPlan premium (about $1,000/person) through the income tax system. Every employer would pay eighty percent of the MediPlan premium on behalf of each working American through a payroll tax of about $.40 per hour to a maximum of $800/year per employee. Thus, each worker would be responsible for $200 of the annual premium.

Low-income persons would not pay the individual's share of the MediPlan premium. Between $8,000 and $16,000 for individuals and $16,000 and $32,000 for married couples, the individual's share of the MediPlan premium would be phased in.

Long-Term Care Coverage Under MediPlan

More than 9 million Americans currently need long-term care services and require assistance with their activities of daily living. The demand for long-term care services will only increase with the projected growth in the elderly population.

Few can afford the staggering costs of long-term care. The average cost of a nursing home has increased to nearly $36,000 per year. For those who purchase home care services to help care for a severely impaired family member with Alzheimer's disease, the costs can easily exceed $15,000 per year.

Despite the high costs of nursing home and long-term home and community-based services, public financial support for long-term care is limited. The Medicare program spends $3 billion per year for home care services, and limits coverage to the elderly and disabled who are both homebound and in need of skilled services. Medicare finances only 2 percent of total nursing home costs. The Medicaid program, by contrast, covers nearly half of the nation's $43 billion nursing home bill, but limits coverage to the poor.

To address the concerns noted earlier with the Pepper Commission's final recommendations, MediPlan includes a number of important features:

- All chronically ill individuals, regardless of age or income, would be eligible for long-term care benefits;
- All chronically ill individuals and their families would have true protection from financially devastating long nursing home stays;
- All chronically ill individuals would have access to the full range of long-term care services, including nursing home, home care and a range of community-based services;
- Under this program, the benefits would not be means-tested; the financing would be progressive.

Comprehensive nursing home benefits would be covered for eligible individuals of all ages and would be phased in over a seven year period. The comprehensive nursing home benefit would provide substantial assistance to families who are concerned about the high cost of a long nursing home stay from a devastating illness such as Alzheimer's Disease.

The first year of implementation would restore the Medicare catastrophic coverage skilled nursing facility (SNF) benefit for 180 days and would repeal the 3-day prior hospitalization requirement. In year three, the nursing home benefit would be expanded to cover all stays for Medicare beneficiaries, with a 12-month deductible period.

Comprehensive nursing home benefits, with a two month deductible, would be fully phased in for the non-elderly by year seven.

Home and community-based long-term care services would also be phased in over a seven year period. Initially, the Medicare home health benefit would be expanded. Comprehensive home and community-based benefits would be phased-in for the elderly by year three and for the non-elderly in year seven.

Individuals would be required to pay the nursing home deductible and 20 percent copayment for nursing home, home and community-based benefits. Individuals with incomes below 200 percent poverty would not be required to pay deductibles and copayments.

I believe it is extremely important to spell out the costs of this long-term care program. Because a comprehensive solution is so very expensive, the financing mechanism is likely to be unpopular.

The long-term care benefits are estimated to cost approximately $60 billion when fully implemented. This bill would include sufficient revenues to fund the new benefits.

Financing MediPlan's Health and Long-Term Care Benefits

MediPlan requires $60 billion to support health insurance for children, pregnant women, and low-income persons and another $60 billion to support long-term care services.

To cover the $120 billion in benefits, revenues would be raised under MediPlan through a four percent tax on gross income, including tax-exempt income, deferred income and other forms of income not currently subject to taxation. Individuals with incomes below 200 percent poverty would be exempt from the tax. All revenues from the MediPlan income tax would be paid into the MediPlan Trust Fund.

CONCLUSION

The Pepper Commission was established to develop a plan that would provide comprehensive health insurance and long-term care services to the people of this country.

In my judgement, the Commission's final recommendations fail to meet these objectives. Consequently, I am unable to support the final report.

While primarily concerned with the absence of specific financing options in the Pepper Commission's final report, I also have serious objections to:

- A "pay or play" approach to expand health insurance coverage that is neither comprehensive nor likely to result in serious cost containment; and

- A long-term care proposal with "front-end" nursing home benefits when many are concerned with the cost of long nursing home stays, and a means-tested benefit for extended nursing home stays.

In addition to my concerns about the Pepper Commission recommendations, I have also outlined my own proposal, MediPlan, which is both comprehensive and self-financing.

I hope that these comments and the description of MediPlan will be used constructively to move the legislative process forward, so that comprehensive health insurance and long-term care services will be a reality for all Americans in the near future.

Congress now has before it a range of bills but the Bush Administration remains silent on health and long-term care coverage. I urge the Administration to present the American public with a proposal to address these problems -- any proposal at all. There would then be a range of options upon which the public could comment and Congress could work its will.

LOUIS STOKES
21ST DISTRICT, OHIO

COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEES:
LABOR/HHS/EDUCATION
HUD/INDEPENDENT AGENCIES
DISTRICT OF COLUMBIA

Congreſs of the United States
House of Representatives
Washington, DC 20515

2365 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-7032

DISTRICT OFFICE:
ROOM 2947
NEW FEDERAL OFFICE BUILDING
1240 EAST 9TH STREET
CLEVELAND, OH 44199
(216) 522-4900

CLEVELAND HEIGHTS OFFICE
2140 LEE ROAD
SUITE 211
CLEVELAND HEIGHTS, OH 44118
(216) 522-4907

July 31, 1990

Senator John D. Rockefeller, IV
United States Senate
Washington, D.C. 20510

Dear Senator Rockefeller:

As we conclude our activities as members of the Pepper Commission, the U.S. Bipartisan Commission on Comprehensive Health Care, I wanted to take the time to convey some personal thoughts and impressions of our activities over the past year. Let me start by saying that it was quite an honor to serve with this prestigious group. For me, it was a unique honor since I replaced our esteemed late colleague, Claude Pepper, who was one of the greatest advocates for health care this nation has ever known. In this respect, I felt an even greater responsibility to achieve the goal of the Commission; to recommend policy solutions assuring the availability of health services and long-term care for all Americans.

As you know, during my tenure in Congress, I have been able to share my concerns about our health delivery system through my work as a member of the House Labor-Health and Human Services-Education Appropriations Subcommittee. While this work has been extremely fulfilling and has allowed me numerous opportunities to impact upon and acquire a working knowledge about our federal health programs, it has been the work of the Commission that immersed me into the full realm of our national health care system and its problems. For me, the Commission represents one of the most comprehensive and exhaustive undertakings of America's health system ever.

To say that our work was complex and lengthy is not an adequate representation of our efforts. How do you explain the masses of background materials that line an entire shelf in my office or the early morning briefings that ran several hours, not to mention the hearings that easily took up half of our day? How do you summarize days of intense dialogue between 12 members that sometimes ran well into the early hours of the morning, or the effort to unify the differing political views and individual philosophies into one opinion on how we as a nation can best address the problems of access to health care and long-term care in the United States? If I had to attempt to sum it up, I would maintain that no stone was left unturned in our deliberations.

For me, as I imagine for most of us on the Commission, our work went well beyond personal ideologies and observations. The unmet health needs of our various constituencies, individually and collectively, demanded that we produce some meaningful solutions to our nation's health care crisis. In particular, the needs of my constituency in the 21st Congressional District of Ohio, the Congressional Black Caucus, and the poor and minority Americans, dictated that I utilize this opportunity to articulate the very pressing and critical problems confronting them. It is my belief that these individuals, who are disproportionately burdened by illness and excess death, and who are forced to seek health care primarily through our nation's emergency rooms or go without care altogether, have the most urgent need for improved access to health and long-term care. With these thoughts in mind, I approached our deliberations with very specific ideas as to what should comprise a minimum level of care that was acceptable for our citizens, and in particular these individuals.

As you will recall, one of the major points of concern that I raised throughout our deliberations involved access to health and long-term care as it related to ability to pay. While I voted in favor of all our recommendations on access to health care and long-term care, I ideologically favor a national system for which there is a greater federal role. This stems from the fact that despite tremendous advances in medicine in the United States, and the significant improvements in our nation's health status, millions of Americans do not benefit fully or equitably from these advances.

There is a large segment of our population that has been abandoned to high infant mortality rates, shortened life expectancy, a crushing burden of illness, debilitating poverty, disability and disillusionment, frustration and loss of hope. In recent years, these problems have been exacerbated by an unprecedented increase in violence, substance abuse, infectious diseases, such as AIDS, and homelessness. Instead of caring about extending health care to all individuals and alleviating these enormous burdens, national attention has centered around the issues of cost containment and the growing budget deficit.

I am disturbed that there no longer seems to be concern about providing the needed financial and other resources to implement an "equal opportunity health care delivery system". I believe that health and long-term care are guaranteed rights of all Americans, and should not be simply available for a privileged few. Our nation must come to grips with the fact that a strong, healthy and educated society will not be realized without a national health care policy that ensures this right.

In guaranteeing access to health care, I strongly supported a minimal health benefit package that focussed on preventive medicine and primary care. These services are key to eliminating the need for costly health care for the medically indigent. I was disappointed, however, that prescription drug benefits were not included in our minimum benefits package. Prescription drugs are preventive in nature by controlling and stabilizing many debilitating and serious diseases for millions of individuals with chronic illness. I was pleased that in our final recommendations the Commission accepted my proposal to include an analysis of the cost-effectiveness of prescription drugs as a preventive service for future consideration as a minimum benefit.

I was also pleased that we established a new federal public health program that made all Americans equal players. No longer would we have one system for the poor and another for those able to pay. Instead, the federal plan would create a system where all persons would receive the same quality of care, and share a common interest in preserving a high quality system.

I was also concerned that the Commission did not adopt a plan based on the assumption that financing would guarantee access. There are many related problems, such as availability of providers, transportation, cultural and linguistic barriers, lack of relevant data, and lack of awareness of available services, that impede our citizens from securing care. It was critical, to my thinking, that these issues receive the necessary attention in our deliberations. Providing solutions to these related problems are as important as providing financing for care.

Additionally, I was worried about how minority small business owners would manage under an employer-provided health insurance system. Therefore, in our discussions, I felt compelled to defend the concerns of minority and other small business owners. Many of these businesses struggle daily, barely making ends meet, and oftentimes, never become profitable. They are however the very essence of life for millions of Americans and the product of years of hard work. To protect these businesses, I felt it necessary to ensure that providing care to employees was not at the expense of their viability. Again, I was pleased that the Commission members shared this feeling and overwhelmingly supported my recommendation to provide, on an ongoing basis, a subsidy for the most vulnerable small businesses.

The concerns I had with the long-term care proposal stemmed primarily from the idea of "protecting assets". This concept, in my opinion, was inappropriate considering the fact that millions of individuals have only a roof over their head and the clothes on their back, let alone "assets" to protect. Once we began to move away from that philosophy and onto one that centered around eliminating financial hardship for the average, moderate income individual, I believe our discussions moved in a much more productive direction.

I also felt strongly that long-term care was not just a problem of the elderly. Americans of all ages are in need of services for chronic, long-term illnesses. While the number of persons under age 65 requiring long-term care is not as large as the number of elderly requiring the same care, their needs are just as important. It is good to know that the Commission's nursing home plan and home-based program, geared to maintaining a person's self-sufficiency and place in the community, are relevant to all persons and are substantive solutions to the long-term needs of this nation.

I was pleased that the views underlying our recommendations on access to health and long-term care are followed through in our proposal on health care for the elderly. Our suggestions allow our elderly the right to grow old with dignity and to receive the health care they need to ensure this. Our plan takes the additional step of safeguarding them from unscrupulous practices in the insurance industry that compromise their well-being.

In the long run, we found that everything depended upon how we would pay for these services. I personally had no problem with making specific recommendations that would change the tax law and raise needed revenues to finance the programs. Many of the current tax laws discriminate against low and moderate income individuals and need to be changed. I recognize, however, that making definitive recommendations about taxes was not necessarily within the purview of our jurisdiction. Therefore, I supported the broad guidelines on what a revenue raising plan should encompass.

I acknowledge that our recommendations did not reflect everything that I or anybody else wanted in terms of access to health and long-term care. Nonetheless, I strongly believe that we provided a well-thought out and meaningful solution that ensures access for all Americans.

I have heard the Pepper Commission recommendations described as a blueprint for action. I can only hope that people will review this report and the accompanying documents as the opportunity for the United States to begin to reform how we provide care to our citizens.

One thing is certain: this issue is the single most complex and important issue we face in this nation in terms of domestic policy. I do not know of any issue that will have a greater impact on our ability to compete and be productive at home and in the international marketplace than health. And no matter what vehicle we choose to deal with this issue, it is going to take the collective effort of all Americans to provide the commitment, leadership and support to meet this great challenge.

I commend you for the outstanding leadership you provided to enable us to produce this extraordinary document. This report will not only serve as a tribute to Claude Pepper and his work, but to you for your determination and dedication to meet the needs of the American people.

I look forward to working with you and my colleagues to meet the challenges that lie ahead.

Sincerely,

LOUIS STOKES
Member of Congress

LS/lla

The Honorable Thomas J. Tauke (Iowa)
Dissenting Views
Final Report of the U.S. Bipartisan Commission on Comprehensive Health Care
August 13, 1990

The Pepper Commission set as its goal the development of a plan to "assure all Americans access to health care coverage that allows them to obtain necessary care and assures them adequate financial protection." I share this goal.

No individual should go without health insurance because he or she is poor. Families should not be forced into poverty when a child or spouse or parent needs long-term home or nursing home care. Individuals who could remain at home with their loved ones with home health care assistance should not be forced into nursing homes or hospitals in order to receive health care coverage.

To achieve this goal, we must confront and meet staggering challenges. Although we are spending more than any other nation on health care, 31 to 37 million Americans lack any health insurance coverage and millions more are underinsured. Health care cost inflation levels are twice those for the rest of the economy, producing sharp increases in insurance premiums for individuals and businesses, pricing increasing numbers of individuals out of the insurance market and making it increasingly difficult for smaller businesses, in particular, to offer or maintain employee health insurance plans.

As the number of uninsured and underinsured increases, and as businesses and federal and state governments clamp down on provider reimbursement in an effort to rein in costs, health care providers are staggering under the growing demand for indigent care and reimbursement rates which do not cover the cost of care. Inner-city emergency rooms, unfortunately the main source of primary care for many uninsured residents, are closing, denying everyone--insured and uninsured--access to care. Across rural America, hospitals are closing and doctors are leaving or restricting their Medicare and Medicaid practices, leaving whole communities or the elderly and indigent within communities without access to basic health care.

At the same time that we confront these challenges of a growing number of uninsured and sharply rising health care costs, the aging of our population confronts us with the need for greater protection against the devastating cost of home and nursing home care for long-term illness and disability.

The current system, a hodgepodge of Medicare for the elderly and the disabled, Medicaid for the poorest of the poor, and employment-linked coverage for the non-elderly and non-poor is part of the problem, not part of or the basis for a solution. Without fundamentally rethinking and restructuring our health care system, we will not achieve the goal of access to affordable health care for all Americans.

In brief, a bare majority of the Pepper Commission signed off on a health care access plan built on the mandate that all employers offer and pay most of the cost of health insurance for their employees or pay a tax to fund a new federally-administered health care plan for the uninsured and unemployed.

Advocates for this approach on the Commission argued that the employer-based system was traditional, accepted by Americans, and generally working well. But just because this is how most Americans have traditionally received health care coverage, is it sound or even logical health care policy? Employer mandates are essentially a head-tax on labor, substantially increasing the cost of employing our most vulnerable citizens--the young, the unskilled, the disabled, the single mother or older woman seeking to enter or re-enter the workforce and the elderly seeking to remain active in the workforce.

The tax incentives supporting our employer-based system of health care coverage add to the inequity and the spiraling cost of our system. Neither the amount the employer may deduct for providing plans nor the value of the benefits received the employee may exclude from income is limited. We are thus subsidizing those who are employed in relatively or very well paid positions providing health benefits, but providing little if any assistance to those most likely to need help in obtaining coverage: the self-employed small businessman, the farmer, the working poor, and the unemployed. We are taxing the working poor to subsidize benefits for those who are far better off.

This unlimited subsidy fuels health care costs as employees negotiate for richer benefit packages and first-dollar coverage, driving up utilization, health care costs in general, and premium costs for those who must purchase coverage individually or as small businesses.

The Commission majority report recommends extending a 100 percent tax deduction, as opposed to the current 25 percent deduction, to small businesses for the costs of providing plans which meet the minimum coverage requirements as outlined by the Commission. While this would equalize the tax treatment of small versus large businesses for health care benefits, it does nothing to address the underlying inequity for the unemployed. Nor does it address the cost problem, since the deductions and exclusions would not be limited to the cost of a basic benefit plan.

If experience is a teacher, the Commission's minimum benefit package would quickly expand. As those among the Commissioners who have circulated similar pay or play employer mandate proposals setting forth a minimum benefit package know all too well, the pressure from provider groups to expand the definition of what constitutes a "minimum benefit package" is enormous and effective.

Employer mandates offer Congress an irresistible temptation: once they are in place, we can respond to perceived social needs and special interest groups by expanding benefits without having to pay for the expansions with tax increases or cuts in other budget areas. We mandate and business pays.

As the definition of minimum expands, costs increase, and employers are required to pay more and more for "basic" coverage, the alternative of the payroll tax to fund the federal public plan will become more and more attractive. If one's ultimate goal is a federally controlled national health care system, employer mandates are a good place to start.

The new public plan envisioned by the Commission's majority report also builds upon the current system rather than questioning the premises of that system and whether we might not find better ways to ensure that all of our citizens have access to affordable health care services and coverage. The new public plan is an expansion of the Medicare program, under which the federal government determines the benefit package for everyone (guided by the advocates for particular services and by what can be squeezed out of the federal budget), purchases services on behalf of the individual, and seeks to ensure access to care and quality of care by regulating the providers of care.

Advocates for this expansion of the federal government's control over the health care system argue that administrative costs are reduced and health care costs more easily contained, since the larger the federal government's role in the system, the greater its clout to negotiate with providers. Our experience with the Medicare program calls into question these assumptions.

If one considers administrative costs to be limited to claims payment and adjudication, the lower administrative cost argument has some merit. That argument does not hold, however, if one also takes into consideration the enormous costs to the health care system of the regulatory burdens Medicare imposes in an effort to constrain costs and ensure access and quality. Resources which could be directed to patient care are diverted to paperwork. Home health nurses, staff nurses, physicians, hospital administrators, and other health professionals with whom I frequently meet report spending much of their time simply attempting to ensure that they are complying with an ever more complex and intrusive body of Medicare regulations.

The federal government, through Medicare, is already one of the largest purchasers of health care services, and the track record on cost containment is bleak. While we have achieved some reduction in Medicare Part A inflation, the rate is still well above general inflation rates. Part B is out of control, with yearly increases ranging from 11 to 13 percent.

Increasing the role of the federal government as a direct purchaser of health care services in an effort to expand access will, in my view, lead to diminished access to many medically necessary services and undermine quality of care. In countries with national health systems run by the government, such as Canada and Britain, for example, costs are controlled by limiting the diffusion of technology, controlling the number of providers, and queuing for higher-cost services. In these systems, the sickest individuals may well wind up waiting the longest for treatment.

My home state of Iowa, with the second highest percent of persons 65 and older as a percent of population and first in the percent of individuals 85 and older, offers a disturbing vision of diminishing access to care under Medicare. In physicians' offices across the state, one finds signs stating that no new Medicare patients will be accepted, with physicians citing low reimbursement rates and excessive regulation as the reasons for limiting their Medicare practices. One of our finest family physicians recently notified his Medicare patients that he was withdrawing entirely from the Medicare program. News accounts of his decision prompted many physicians to write to me, expressing their understanding of the physician's decision and contemplating similar steps. Many are simply retiring earlier.

It is sadly ironic that as the Soviet Union and the nations of Eastern Europe are modifying or abandoning their failed centrally controlled economies and adopting our consumer and market-oriented model to ensure access to goods and services and the quality of those goods and services, we are moving in the opposite direction in health policy.

The 8-7 vote on the Commission's health care access plan does not reflect the degree of dissatisfaction and frustration that I and, I believe, a number of my fellow Commissioners felt with this plan and the failure of the Commission to give more serious and thorough consideration to alternatives to that plan. I would note that at the Commission's two-day retreat several months prior to the issuing of its preliminary recommendations, a majority of the Commissioners voted to reject the plan, and six of us put alternative plans before the Commission, ranging from a modified tax credit/voucher approach to a federal national health insurance system.

I put before the Commission an alternative plan for ensuring universal access to health care coverage, a plan built upon consumer choice and a competitive market. The plan is designed to retain the strengths of our employment-based system, make tax subsidies more equitable, provide catastrophic coverage, extend coverage to the poor and uninsured, and provide Medicare beneficiaries with greater freedom of choice.

While philosophically I question the assumption that health insurance should be a job-related benefit simply because it has been traditionally, I recognize that this system has several strengths, chief among them the power of group purchasing and the innovations that business is now adopting to manage care and control costs. Under my plan, the tax incentive for businesses to continue to offer coverage would be retained. The employer tax deduction would be converted to a refundable tax credit. In order to receive the credit, the plan would have to cover a set of federally determined basic health benefits, would have to afford catastrophic coverage, including case-managed home care for disabled children and adults, and would have to be federally certified. The amount of the tax credit would reflect the average cost of a plan, regionally, meeting these basic requirements in a selected base year, with the credit indexed for general inflation in the succeeding years.

State mandates would be pre-empted to the extent required to allow employers and insurers to offer at least one plan meeting the federally defined minimum basic benefit plan.

Similarly, the employee exclusion would be converted to a refundable tax credit, with the amount determined as the employer tax credit is determined.

For the unemployed and uninsured, I proposed replacing the current Medicaid program with entitlement to a sliding scale voucher or tax credit to be used for the purchase of federally- or state-certified health insurance plans which meet federally-established minimum basic benefit requirements similar or identical to those for employer-based plans eligible for a federal tax credit, including catastrophic coverage. Insurers and competitve medical plans would enter into an annual bidding process at the federal or state level to determine the price of the coverage, adjusted for geographic differences in health care costs and actuarial factors such as health status. The amount of the voucher or credit would be set at a level to guarantee recipients a sufficient choice among competing plans and would vary with family income, size, and other factors. Individuals would be allowed to supplement the voucher/credit.

To help the consumer choose wisely, my plan calls for providing information and personal counseling through state insurance commissions and state and federal agencies serving the poor and the elderly.

For such an approach to work, a method for ensuring that everyone is enrolled in a plan is needed. I proposed automatically enrolling those who failed to select a plan themselves upon initial contact with a health care provider and/or conditioning the receipt of other federal benefits on having insurance.

I realize that this approach is not without some substantial implementation issues, such as adverse selection, that would have to be addressed with further thought. Adverse selection might be addressed by mechanisms for cross-subsidization, but is clearly one major potential problem that might discourage plans from participating.

But the advantages over the current system are clear. Medicaid benefits and eligibility standards vary widely by states, and reimbursement levels are generally so low that many providers are unwilling to accept Medicaid patients. Entitlement to Medicaid does not translate to access to care for many individuals. A voucher/tax credit "mainstreams" the poor, providing them with the dignity--and responsibility--of choice.

Insurers will be competing for plan participants on the basis of the ability to manage care to keep costs down and premiums competitive, to provide quality care, and to provide plans tailored to the needs of consumers.

Initially, the costs of this approach to the federal government will be more substantial than the costs associated with the Commission's employer mandate/federal public plan proposal. However, my plan shifts the locus of cost containment to the plan level, where it can be far more effectively handled than through federal regulation (as Medicare has revealed), and the government's risk in any one year is limited.

I would afford Medicare beneficiaries, as well, with enhanced choices by expanding their current option of enrolling in HMOs to cover other plan configurations and choices among various benefit configurations. For example, a catastrophic coverage option covering long-term home and nursing home care could be offered for approximately the same cost as the current Medicare plan by increasing deductibles and co-payments for basic health care services, which are easier to self-insure against.

Turning to the Commission's long-term care recommendations, and particularly the nursing home care recommendations, I see the rationale for providing three months of initial coverage, thus preserving the resources of individuals so that if they are able, they can return to their homes and communities. But I do not believe it is equitable public policy to impose no means test on the receipt of this assistance and on the open-ended entitlement to home health care services. The Commission's recommendations in effect call for taxing struggling Iowa families to the conservatively estimated tune of $44 billion a year to pay for home and nursing home care for the wealthy and well-off who could well afford to pay for all or most of their care. With means testing, we could extend a greater period of nursing home care protection to those with modest resources.

For these reasons, I could not support the Commission's recommendations.

While we did not achieve consensus on the recommendations for ensuring access to care and were also divided on the long-term care recommendations, we were united in our belief that health care is a fundamental right.

I look forward to continuing to work with my colleagues in Congress on the development of comprehensive reforms to ensure that every individual has access to high-quality, affordable, basic health care coverage.

ONE HUNDRED FIRST CONGRESS
SECOND SESSION

HENRY A. WAXMAN, CALIFORNIA, CHAIRMAN

JAMES H. SCHEUER, NEW YORK
RON WYDEN, OREGON
GERRY SIKORSKI, MINNESOTA
JIM BATES, CALIFORNIA
TERRY L. BRUCE, ILLINOIS
J. ROY ROWLAND, GEORGIA
EDOLPHUS TOWNS, NEW YORK
CARDISS COLLINS, ILLINOIS
MIKE SYNAR, OKLAHOMA
RALPH M. HALL, TEXAS
DENNIS E. ECKART, OHIO
BILL RICHARDSON, NEW MEXICO
JOHN D. DINGELL, MICHIGAN
(EX OFFICIO)

EDWARD R. MADIGAN, ILLINOIS
WILLIAM E. DANNEMEYER, CALIFORNIA
BOB WHITTAKER, KANSAS
THOMAS J. TAUKE, IOWA
THOMAS J. BLILEY, JR., VIRGINIA
JACK FIELDS, TEXAS
HOWARD C. NIELSON, UTAH
MICHAEL BILIRAKIS, FLORIDA
NORMAN F. LENT, NEW YORK
(EX OFFICIO)

KAREN NELSON, STAFF DIRECTOR

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

2415 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
PHONE (202) 225-4952

August 10, 1990

The Honorable John D. Rockefeller, IV, Chairman
United States Bipartisan Commission on Comprehensive
Health Care
140 Cannon House Office Building
Washington, D.C. 20515

Dear Jay:

As you know, I voted to support the Commission recommendations. I did so despite the substantial differences between the Commission's plan and the legislation I have introduced: the Basic Health Benefits for All Americans Act (H.R. 1845) and the Elder-Care Long-Term Care Assistance Act of 1989 (H.R. 3140). The Commission's recommendations are compromises resulting from months of study and discussion. In my view, they define the middle ground in the debate over solutions to our nation's health care and long-term care crises.

Access to Health Care Reform

Our nation only has three real choices for addressing the needs of the 31 to 37 million uninsured Americans. We can maintain the status quo, perhaps tinkering at the margins with some modest reforms in the small business health insurance market and in the Medicaid program. This will still leave millions uninsured, and millions more with inadequate basic coverage. We can completely overhaul our current financing and delivery system, moving towards a single national or regional governmental payor model like Canada. This would represent a radical departure from our existing system and a massive transfer of funds currently spent in the private sector to the public budget. I do not believe that is a political viable alternative at this point, certainly, not until we have given an improved employment-based system an opportunity to work. Or we can do what the Commission recommends: build upon the existing employer-based system through which most Americans obtain their health care coverage, and provide basic coverage for those not connected to the workforce through a new public program that is not tied to welfare. That path seems to me the best way to move.

While I support the Commission's recommendations, I believe that they can and should be strengthened in two areas: cost containment, and eliminating State responsibility for financing the new public program.

Cost Containment

We will never enact the badly-needed reforms that the Commission recommends unless we persuade private employers and insurance plans that they will have some effective leverage against providers to protect themselves from unreasonable cost increases. Moreover, we should also take steps to insure that charges for services no longer include the costs of providing care to those without coverage. Such adjustments will, of course, help to reduce the amount of new public support required to implement the Commission's recommendations.

The Commission's report includes a number of recommendations, including the development and implementation of national practice guidelines and an emphasis on managed care -- that would put downward pressure on the rates of increase in public and private health care spending. While I support these recommendations, I do not believe they are sufficient.

My own view is that, in order to be credible on cost containment, we have to take two additional steps.

First, hospitals and physicians should be required, as a condition of participation in either Medicare or the new public program, to accept payment rates and balance billing limits established in accordance with Medicare principles for services rendered to any privately insured individual, if that individual's health plan so requests. This would not preclude insurers and self-administered plans from negotiating rates more favorable than those available under Medicare. Nor would it require private purchasers to use Medicare rates. But it would give them the option of limiting their financial exposure. The Medicare hospital and physician payment rules offer protection against unreasonable or unpredictable cost increases. They were developed with cost containment as one objective and, for the foreseeable future, will be administered by the Federal government with cost containment in mind.

Second, all employers, small or large, should be given the option of buying basic coverage for their employees and dependents from the new public plan on a community rated basis. This idea was advocated by the Chrysler Corporation at a hearing on April 26 before the Subcommittees on Health and Environment and on Commerce, Consumer Protection, and Competitiveness. As Chrysler pointed out, giving employers this option "should serve to spur the private sector to come up with even better products."

State Financial Participation

As Chairman of the Subcommittee with Medicaid jurisdiction, I am well aware of the inability or unwillingness of many States to commit adequate resources to the Medicaid program. As the Commission report documents, the result of this is unacceptable variation in eligibility, benefits, and payment policies from State to State. To the extent that States are expected to make significant financial contributions to a health program, they will demand flexibility in administering the program to accommodate their fiscal capacity and priorities. The resulting variation will undermine efforts to achieve the Commission's goal of universal access to basic health care.

Consider what State flexibility has meant in the Medicaid program. States recognize that by limiting eligibility, scope of benefits, and reimbursement, they can contain their Medicaid spending. Many have used the flexibility they have under current law to do so. For example, as of July, 1989, some States covered all pregnant women and infants with incomes up to 185 percent of the Federal poverty level, while others covered only those with incomes below 75 percent of the poverty level. With respect to benefits, some States covered all medically necessary inpatient hospital services; others imposed durational limits such as 18 days per year. Finally, some States use Medicare reimbursement rules in paying for physician services; others set fees that average as little as 52 percent of what physicians charge their private patients.

Recognizing that an employer-based approach will not reach those outside the workforce, the Commission recommends a new Federal entitlement program to replace the acute care portion of Medicaid. The Commission properly recognizes that, in order for this new public program to work and be accepted by the American people, it must be separated completely from the welfare system. The Commission properly recommends that the administration of the new public program be transferred out of State Medicaid and welfare agencies to the Federal government, which could in turn contract with private carriers or State agencies unrelated to welfare programs. Unfortunately, the Commission also recommends that the States help finance the new program at the same level at which they are financing acute care benefits under Medicaid, adjusted upward each year for inflation.

This is financially and politically unstable and may not be sustainable over time. It places the States in the position of having to make fixed -- but large and increasing -- financial contributions for a program over which they would no longer have administrative control. For many States, this is simply not a realistic fiscal proposition over the long term. The political instability of this arrangement would most probably result in a return of administrative control and flexibility to the States, leading to variations in eligibility, benefits, and reimbursement that would compromise the program's access goals. If we are serious about health care reform, then we must extricate health care from the welfare system completely. This means Federalizing not just the administration but also the financing of any new public program.

I recognize that my approach would add, by the Commission's estimates, at least $12 billion per year to the cost of the new Federal program. And I realize that such a large transfer of costs from the State to the Federal government would have to be phased in over a period of years. But 25 years of experience with Medicaid teaches us one thing: to pay for the new public program through substantial State funding is to doom it to failure. We should relieve States, as quickly as possible, of the financial and administrative burden of operating the acute care portion of their Medicaid programs. Even in low benefit, low eligibility, low reimbursement States, this will free up significant State dollars to help them meet their obligations under the Commission's long-term care recommendations.

Long-Term Care Reform

As is the case with the uninsured, our Nation has limited practical choices for addressing the needs of Americans requiring long-term care. We can maintain the status quo -- which is to say -- we can continue to provide only restricted coverage for home and community-based services under Medicare, require impoverishment and indignity as pre-requisites for nursing home care under Medicaid, and hope that the private sector will take on a large chunk of the problem. We can try to make small improvements -- such as the Medicaid Frail Elderly proposal that we are both sponsoring -- in the federally-financed health care programs. But as our country's life expectancy rate continues to rise, such an approach would still leave millions without any long-term care assistance at all, and millions more with inadequate protection.

We can also learn from our past experience -- from both the successes of Medicare and the failures of Medicaid as well as the limitations of the private insurance market -- and design a system that will ensure access to all long-term care services to all frail and disabled Americans. Such a system would build upon Medicare's social insurance approach; eliminate Medicaid's requirement of "spend-down" to a level of extreme poverty before any assistance is provided; and encourage the private market's development of insurance plans (in accordance with Federal standards) to supplement a basic Federal long-term care program much as today's Medigap policies are supposed to complement current Medicare benefits.

This is the approach the Commission has elected to follow and is the one I think best to pursue. While I recognize and appreciate the short-term difficulties in putting the program into place, I do believe that, in the long run, it would not only help achieve the Commission's goal of assuring Americans access "to coverage that provides . . . necessary long-term care and adequate financial protection"; it would also go a long way in avoiding the deficiencies and shortcomings of today's basic health care system.

As you know, I had hoped -- and, indeed, I pushed -- for the Commission to recommend a comprehensive Federal long-term care program based upon social insurance principles. And although the Commission elected to do something less than that with respect to coverage for nursing home care, its recommendations do include two significant proposals regarding coverage for nursing home services.

First, the Commission's recommendations provide for good social insurance coverage for those who will stay in a nursing facility only for a short while. Such coverage will allow these individuals to return to their own homes with their financial resources and their community life very much in tact. Second, the Commission's recommendations provide for protection against impoverishment for those who face lengthy nursing home stays. And while that protection will not be available to all individuals who require such care, the $30,000/$60,000 asset protection plan proposed by the Commission is a vast improvement over what is now available under the Medicaid program. The plan offers help to those who have been been hurt most by the current system and it provides full protection for the life savings of three out of five of today's elderly Americans. As such, it cannot be construed or operated as a "welfare" program.

These proposals -- coupled with the Commission's recommendations regarding home health benefits -- comprise a sound, practical, and very much "doable" approach to resolving this country's long-term care crisis. I hope we can move forward with it as quickly as possible.

Conclusion

It has been a privilege to serve with you on the Commission. I look forward to working with you and other Commissioners to introduce legislation setting forth the Commission's recommendations and to secure the enactment of this legislation in the next Congress.

The trend lines are not favorable. If we are not careful, we could debate away half the decade, and find ourselves approaching the year 2000 with far more uninsured, far higher costs, far more frail elderly, and no reforms in place. We have to begin phasing in solutions to the twin crises of access to health care and long-term care. The publication of the Commission's report would be a good place to start.

With every good wish, I am,

Sincerely,

HENRY A. WAXMAN
Chairman, Subcommittee on
Health and the Environment

Appendixes

Appendix A

Commission Activities, May 1989–March 1990

HEARINGS

"Access to Health and Long-Term Care"
St. Louis Park, Minnesota
May 25, 1989

Rev. Joseph Head, Grace Nelson, Bob Opland, Diana Seeger, Sue Stevens, Floyd Weese, who have had difficulties with access to health care or to long-term care.

Rich Bringewatt, senior vice president, Altcare, Bloomington, MN

Pat Drury, executive director, Minnesota Coalition for Health

Kevin Fickensher, M.D., director, Center for Rural Health, North Dakota

Sandra Gardebring, commissioner, Minnesota Department of Human Services

LaVohn Josten, director, Public Health Nursing Section, Minnesota Department of Health

Robert Kane, M.D., dean, School of Public Health, University of Minnesota; member, Advisory Panel on Alzheimer's Disease, U.S. Department of Health and Human Services

Gayle Kvenvold, president and CEO, Minnesota Association of Homes for the Aging

Sheila Leatherman, vice president, research and development, United Health Care, MN

LuAnne Nyberg, director, Children's Defense Fund—Minnesota

Rep. Bob Ogren, Minnesota House of Representatives; chair, House Health and Human Services Committee

Cynthia Polich, president, InterStudy

James Reinertsen, M.D., president and CEO, Park Nicollet Center, St. Louis Park, MN

Harry Sutton, consultant, Governor's Commission on Health Plan Regulatory Reform in Minnesota

Dale Thompson, president, Health Dimensions, Inc.; vice president, Region 5, American Health Care Association

Donald Wegmiller, M.D., president and CEO, Health One Corporation; former chair, board of trustees, American Hospital Association

"Health Care in Rural America: The Frontier Perspective"
Missoula, Montana
June 28, 1989

Harry Higgins, Kent and Nora Olson, and Ruth Torrence, who have had difficulties with access to health care or to long-term care

Jane Anderson, director, Area V Agency on Aging, Anaconda, MT

Alan Cain, president, Blue Cross/Blue Shield of Montana

John Coombs, M.D., vice president, medical affairs, Tacoma Hospital, Tacoma, WA; chairman, Rural Subcommittee, American Academy of Family Physicians

William J. Downer, Jr., chairman, Montana Hospital Association; president and CEO, Columbus Hospital, Great Falls, MT

James Eskridge, general manager, Sun River Electric Co-op, Inc., Fairfield, MT

Don Espelin, M.D., chief, Preventative Health Services Bureau, Montana Department of Health and Environmental Services

Patricia Hennessy, M.D., St. Ignatius, MT

Rose Hughes, executive director, Montana Health Care Association

Kay Jennings, director, Certified Home Health and Medicaid Waiver Programs, Sydney, MT

Geri Larson, R.N., director of nursing, Clark Fork Valley Hospital, Plains, MT

Steven Stanley, administrator, Horizon Lodge Retirement Center and Assisted Living, Conrad, MT

David Wheeler, representing Montana Nurses Association

"Business, Labor, and Consumers: Views on Health Care and Long-Term Care"
Cincinnati, Ohio
July 5, 1989

Barbara Dick, Deborah Rigg, and Joseph Sieber, with personal stories about access to health care or to long-term care

James Bell, manager, Corporate Health Care Benefits, Proctor and Gamble

Stanley E. Broadnax, M.D., commissioner, Cincinnati Department of Health

Charles Brumfield, director for labor relations, AT&T, Morristown, NJ

Charles Carroll, vice president, Proctor and Gamble

Ken Daily, Green County Council on Aging, Green County, OH

Judy Daniels, M.D., director, Cincinnati Health Services Network

Gene Elkus, board member, National Multiple Sclerosis Society

Judith B. Green, board member, Cincinnati Area Senior Services

Sarah Grim, president, Greater Dayton Area Hospital Association

James Irvine, vice president, Communications Workers of America, Somerset, NJ

John Lucia, consultant, Employee Benefits and Policies, Proctor and Gamble

Solomon Marble, president, Ohio Chapter, American Federation of State, County, and Municipal Employee Retirees

Lynn Olman, president, Greater Cincinnati Hospital Council; chairman, Greater Cincinnati Chamber of Commerce Health Care Committee

Paul Polocicchio, international vice president, Service Employees International Union, AFL-CIO; president, SEIU Local 79, Michigan

William Reina, associate manager of personnel administration, Proctor and Gamble

Stephen D. Wilhide, president, Southern Ohio Health Services Network, Cincinnati, OH

"Small Business Health Care Problems and Long-Term Care"
Cleveland, Ohio
July 6, 1989

Susanne Dotson, John Hexter, Gary Stansbury, and Donald Wilson, who testified on problems with availability and affordability of health insurance for small businesses

Patricia Davis, Diane Godessa, Chris Hall, Ruth Reinking, Kathy Yane, with personal stories about long-term care

Janet L. Auburn, executive director, North Coast Health Ministry, Lakewood, OH

Robert Binstock, Ph.D., Department on Aging, Health, and Society, Case Western Reserve University

Ken Campbell, director, Ohio Developmental Disabilities Planning Council, Columbus, OH

Theodore Castele, M.D., Ohio State Medical Association

Ed Chardnock, M.D., Ohio State Medical Association

Sharon Eckert, executive director, Cleveland Chapter of Alzheimer's Disease and Related Disorders Association, representing the Ohio Long-Term Care Action Network

Doris Freedman, director of interagency policy, Office of Advocacy, U.S. Small Business Administration

Kenneth Frisof, M.D., director, Northeast Ohio Coalition for Health Insurance

John Galles, executive vice president, National Small Business United, Washington, DC

John Gillespie, vice president, Metro Health System, representing the Greater Cleveland Hospital Association

W. David Helms, senior program consultant, Health Care for the Uninsured Program, Robert Wood Johnson Foundation

Alma Krekus, attendant care coordinator, Services for Independent Living

Glynis Laing, R.N., Ph.D., director, Lutheran Hospice Community Program, Cleveland, OH

Werner Lange, community specialist, Interchurch Council of Greater Cleveland

John Morley, president and CEO, Reliance Electric, representing Cleveland Health Quality Choice and the Health Policy Coalition

John Polk, executive vice president, Council of Smaller Enterprises, Cleveland, OH

John Roller, president, Council of Smaller Enterprises, Cleveland, OH

Teresa Saxton, representing Visiting Nurses Association of Cleveland

Charles D. Weller, attorney, Jones, Day, Revis and Pogue; representing Cleveland Health Quality Choice and the Health Policy Coalition

Paul Woods, vice president of human resources, Nestle, representing Cleveland Health Quality Choice and the Health Policy Coalition

"The Insurance Industry and Access to Health Care and Long-Term Care"
Des Moines, Iowa
August 21, 1989

Debbie Gansemer, Mark Kennis, and Ray Morgan, who have had difficulties with health insurance or access to health care

Julie Beckett, Nancy Klein, and Pat McCollom, who have personal experiences with long-term care for children and younger disabled adults

Betty Grandquist, Maury Hunter, and Kathleen Vermeer, who have personal experiences with long-term care for the elderly

Ray Crabtree, senior vice president, Principal Financial Group, Des Moines, IA

Beth Fuchs, Ph.D., specialist, Social Legislation, Education and Public Welfare Division, Congressional Research Service

Janet Griffin, associate counsel, Blue Cross/Blue Shield of Iowa

Paul Pietzsch, president, Health Policy Corp. of Iowa, Inc.

Earl Pomeroy, vice president, National Association of Insurance Commissioners

Robert D. Ray, co-chairman, National Leadership Commission on Health Care; governor, state of Iowa, 1969–83

Trevor Smith, assistant insurance commissioner, state of Florida

"Long-Term Care in Rural America: A Family and Health Policy Challenge"
Little Rock, Arkansas
August 22, 1989

Mary Anita Andrews, Velma Gilbert, Debra Nelson, and Edrell Trickle who have personal experiences with long-term care

Roger Bausfield, M.D., president, Arkansas Hospital Association

Joyce T. Berry, Ph.D., acting commissioner, Administration on Aging, U.S. Department of Health and Human Services

Rep. Bill Foster, member, Arkansas House of Representatives; chairman, Aging and Legislative Affairs Committee

Rosalie Kane, D.SW., professor of social work and public health, University of Minnesota

Sen. Mike Kinard, member, Arkansas Senate; member, Aging and Legislative Affairs Committee

DeMaris Marsh, state director, Arkansas Chapter, American Association of Retired Persons

James Maupin, M.D., Arkansas State Board of Health

Amber Reed, president-elect, Arkansas Association of Home Health Agencies

Benno Salewski, executive director, Arkansas Health Care Association

Herb A. Sanderson, deputy director, Division of Aging and Adult Services, Arkansas Department of Human Services

Floyd Sexton, member, Arkansas Seniors Organized for Progress

Ernie Yeager, member, Arkansas Pharmacists Association

"Long-Term Care and Access to Health Care: Examining the Scope of the Problems"
Washington, D.C.
September 21, 1989

Cheryl Gresek, Ipswich, MA; Greg Nugent, Phoenix, AZ; Pamela Young, Dickson, TN; who have had difficulties with health insurance or access to health care

Marilyn Rubin, West Hartford, CT; Deborah and Scott Russell, Kalamazoo, MI; Jim and Rebecca Schienle, Los Angeles, CA; who have had difficulties with long-term care

Robert Blendon, Sc.D., professor and chairman, Department of Health Policy and Management, School of Public Health, Harvard University

Carroll Estes, Ph.D., director, Institute for Health and Aging, University of California, San Francisco

Walter Maher, director, federal relations for the Human Resources Office, Chrysler Motors Corporation

Deborah Steelman, chair, Quadrennial Advisory Council on Social Security

Louis W. Sullivan, M.D., secretary, U.S. Department of Health and Human Services

John Sweeney, international president, Service Employees International Union; chair, AFL–CIO health care committee

"Options in Long-Term Care"
Washington, D.C.
October 5, 1989

Frank R. DeGeorge, associate legislative director, Paralyzed Veterans of America

Lois Evans, D.N.Sc., R.N., assistant professor of Gerontological-Psychiatric Nursing Program, University of Pennsylvania, representing American Nurses Association

Richard Gehring, board chairman, Alzheimer's Association

Lou Glasse, president, Older Women's League

Sheldon Goldberg, president, American Association of Homes for the Aging

Diane Justice, deputy director, National Association of State Units on Aging

Charles O. Kelly, family member, National Alliance for the Mentally Ill, representing the Mental Health Coalition

Jean McGuire, executive director, AIDS Action Council

Martha McSteen, president, National Committee to Preserve Social Security and Medicare

Ronald F. Pollack, executive director, Families USA

Carl Schramm, Ph.D., president, Health Insurance Association of America

Richard Schweiker, president, American Council on Life Insurance

Mildred Shapiro, associate commissioner for Medicaid, New York State Department of Social Services

Gail Shearer, manager, public policy, Consumers' Union

Mary Suther, president and CEO, Visiting Nurses Association of Texas, representing National Association for Home Care

Paul Willging, Ph.D., executive vice president, American Health Care Association

Carolyn Zollar, director of government relations, National Association of Rehabilitation Facilities, representing National Rehabilitation Coalition

"Options in Access to Health Care"
Washington, D.C.
October 24, 1989

Lovola Burgess, vice president, American Association of Retired Persons

Thomas R. Burke, A. Foster Higgins & Co.

Arthur S. Flemming, chairman, National Health Care Campaign

Melvin A. Glasser, director, Committee for National Health Insurance

Sam Havens, chairman, finance committee, Group Health Association of America

Kathleen M. Higgins, C.N.M., representing American College of Nurse-Midwives

Robert Hunter, president, National Insurance Consumer Organization

Sen. William V. Irons, Rhode Island State Senate, representing National Association of Life Underwriters

Marvin Kolb, M.D., chair, Council on Government Affairs, American Academy of Pediatrics

Barbara Matula, state Medicaid director for North Carolina, representing American Public Welfare Association

Stephen Monson, representing the Consortium for Citizens with Disabilities

John Motley, director of government relations, National Federation of Independent Business

Bruce Mueller, vice president and corporate director of benefits and personnel systems, Motorola, Inc., representing National Association of Manufacturers

Vivian W. Pinn-Wiggins, M.D., president, National Medical Association

Sara Rosenbaum, director of programs and policy, Children's Defense Fund

Paul Rettig, executive vice president, American Hospital Association

Rep. Edward R. Roybal, U.S. House of Representative; chairman, House Select Committee on Aging

Carl Schramm, Ph.D., president, Health Insurance Association of America

Eric Schulman, director of legislation, National Council of Senior Citizens

Bernard R. Tresnowski, president, Blue Cross/Blue Shield

Rep. Doug Walgren, U.S. House of Representatives

"Assessing the Affordability of Private Long-Term Care Insurance"
Washington, D.C.
November 8, 1989

Bruce Jacobs, director, Public Policy Analysis Program, University of Rochester

Stanley Wallack, president, LifePlans, Inc.; director, Bigel Institute, Brandeis University

Joshua Weiner, senior fellow, The Brookings Institution

"The Shadow Caregivers: American Families and Long-Term Care"
Philadelphia, Pennsylvania
November 13, 1989

Jack Armstrong, Miriam Burnett, Stewart and Terry Idelson, Christina Rodgers, Joyce Singer, who have personal experiences with long-term care

Charles Daly, vice president, Delaware Valley Hospital Association

James Dorsch, Washington counsel, Health Insurance Association of America

Dan English, president, Action Alliance of Pennsylvania

Adele Hebb, president, Community Home Health Services of Pennsylvania

Maggie Kuhn, founder and national convener, Gray Panthers

Mary Kay Pera, executive director, Pennsylvania Association of Home Health Agencies; coordinator, Pennsylvania Long-Term Care Campaign

Linda Rhodes, secretary, Pennsylvania Department of Aging

"Long-Term Care and Access to Health Care: The West Virginia Experience"
Charleston, West Virginia
December 13, 1989

Debbie Belcher-Smith, Charles Keeney, Rev. Daniel Edward Oakes, who have had difficulties with long-term care or access to health care

Lee Beard, representing West Virginia Federation of Labor

David K. Brown, executive director, West Virginia Commission on Aging

Bea Burgess, former president, Council of Senior West Virginians

Harold P. Freeman, M.D., president, American Cancer Society

Phillip H. Goodwin, president, Charleston Area Medical Center

John Hurd, president, West Virginia Chamber of Commerce

Earl Jarvis, director of aging problems, PRIDE of Logan County

Derrick Latos, M.D., president, West Virginia Medical Society

Kayetta Meadows, president, West Virginia Education Association

Gerry Stover, administrator, Lincoln County Primary Care Center

James T. Sykes, professor, School of Medicine, University of Wisconsin; chairman, Public Policy Committee, National Council on the Aging

Robert Walker, M.D., chairman, Department of Family and Community Health, Marshall University Medical School

Del. Patricia Holmes White, member, West Virginia House of Delegates; administrator, West Virginia Health Right

Taunja Willis-Miller, secretary, West Virginia Department of Health and Human Resources

WORKING SESSIONS

"Coming to a Consensus on Access to Health Care: Experience of the National Leadership Commission on Health"
Washington, D.C.
May 17, 1989

Robert D. Ray, J.D., co-chairman, National Leadership Commission on Health Care; governor, state of Iowa, 1969–83

Paul G. Rogers, LL.B., co-chairman, National Leadership Commission on Health Care; member, U.S. House of Representatives, 1955–79; chairman, Subcommittee on Health and the Environment of the Committee on Energy and Commerce, 1971–79

Stuart H. Altman, Ph.D., dean, Florence Heller Graduate School for Social Policy, Brandeis University; professor of national health policy, Brandeis University; chairman, Prospective Payment Assessment Commission

Uwe E. Reinhardt, Ph.D., professor of political economy, Woodrow Wilson School of Public and International Affairs, Princeton University; member, Private Sector Task Force on Health Policy, U.S. Department of Health and Human Services

"Coming to a Consensus on Access to Long-Term Care: A Discussion on Defining the Issues"
Washington, D.C.
June 1, 1989

Robert N. Butler, M.D., Brookdale Professor and chairman, Gerald and May Ellen Ritter Department of Geriatrics and Adult Development, Mount Sinai Medical Center, New York, NY

Lynn Etheredge, consultant, public and private health care financing and income security issues

Jay N. Greenberg, Ph.D., executive vice president, LifePlans, Inc., Waltham, MA

"Exploring the Roles of the Public and Private Sector in Financing Long-Term Care"
Washington, D.C.
June 21, 1989

Robert M. Ball, chair, board of the National Academy of Social Insurance; former U.S. commissioner of social security

F. Peter Libassi, senior vice president, Travelers Companies, Hartford, CT

"Problems of the Uninsured with Emphasis on the Employed Uninsured"
Washington, D.C.
July 13, 1989

Stanley B. Jones, health policy consultant; former staff director, Subcommittee on Health, Committee on Labor and Public Welfare, U.S. Senate

Jack A. Meyer, president, Economic and Social Research Institute; founder and president, New Directions for Policy

Kenneth E. Thorpe, Ph.D., director, Program on Health Care Financing and Insurance, School of Public Health, Harvard University; assistant professor, Department of Economics, Harvard University

"Options for Improving Access to Health Care"
Washington, D.C.
July 20, 1989

Karen Davis, Ph.D., chairman, Department of Health Policy and Management, School of Hygiene and Public Health, Johns Hopkins University; professor of economics, Johns Hopkins University; director, The Commonwealth Fund Commission on Elderly People Living Alone; member, Physician Payment Review Commission

Rashi Fein, Ph.D., professor of the economics of medicine, School of Medicine, Harvard University; senior staff, Council of Economic Advisers to President John F. Kennedy

Lawrence S. Lewin, president, Lewin/ICF

Gail R. Wilensky, Ph.D., vice president, division of health affairs; director, Center for Health Affairs, Project HOPE; member, Physician Payment Review Commission

"Health and Long-Term Care Systems in Canada and Other Industrialized Nations"
Washington, D.C.
July 27, 1989

Allan Detsky, M.D., Ph.D., associate professor, Department of Health Administration and Medicine, University of Toronto; director and staff physician, Division of General Internal Medicine and Clinical Epidemiology, Department of Medicine, Toronto General Hospital.

John K. Iglehart, founder and editor, *Health Affairs;* national correspondent, *New England Journal of Medicine*

Rosalie Kane, D.SW., professor of social work and public health, University of Minnesota; editor-in-chief, *The Gerontologist*

George Schieber, Ph.D., director, Office of Research, Office of Research and Demonstrations, Health Care Financing Administration, U.S. Department of Health and Human Services

"Minority Health Care"
Washington, D.C.
October 31, 1989

Herbert W. Nickens, M.D., vice president, Association of American Medical Colleges; former director, Office of Minority Health, U.S. Department of Health and Human Services

John H. Skinner, Ed.D., assistant dean, School of Public Health, University of South Florida

Other Working Sessions

Washington, D.C.
September 28, 1989

Washington, D.C.
October 19, 1989

Washington, D.C.
October 26, 1989

Washington, D.C.
November 8, 1989

Washington, D.C.
November 14, 1989

Washington, D.C.
December 15, 1989

Annapolis, Maryland
(Working session/retreat)
January 5–6, 1990

Washington, D.C.
February 5, 1990

Washington, D.C.
February 28, 1990

Washington, D.C.
(Voting meeting)
March 2, 1990
Recommendations announced

Appendix B

Health Care and Long-Term Care Options

In developing its recommendations on health care and long-term care, the Commission carefully evaluated a variety of options. To understand the full reasoning behind the Commission's choices, it is useful to review the alternatives the Commission considered and ultimately rejected. All cost estimates are for 1990 and assume full implementation in that year.

HEALTH CARE

Two alternatives to the Commission approach that are often proposed to ensure health care coverage for all Americans are (1) expanding public coverage for the poor and helping others purchase private insurance on a voluntary basis, and (2) replacing the current job-based system with national health insurance. The Commission evaluated these options primarily in terms of the amount of additional coverage they would provide, their disruption of current practices, and their costs to the taxpayer.[1] Table B-1 and Figures B-1 and B-2 compare the options to the Commission's recommendations.

Expanding Public and Promoting Private Coverage

Most options for helping people obtain health insurance involve providing coverage to the poor and assisting the near-poor to purchase coverage. This combination attempts to expand existing coverage mechanisms to people now left out. It retains the voluntary nature of our current system and enables individuals to make their own choices about health insurance.

The Commission looked at several options to extend coverage to the poor and near-poor—including broadening Medicaid eligibility as well as providing an array of subsidies to small employers and individuals. A variation that illustrates the effect of these approaches would:

- Provide public insurance free to all those whose family income is below poverty;
- Set provider payments at rates set according to Medicare rules, rather than at Medicaid rates;
- Reform the health insurance market to ensure that private insurance is available to all those willing to purchase it;
- Provide a sliding-scale subsidy to those whose family incomes are between poverty and twice poverty so they could purchase private insurance.

This proposal would cost the federal government an estimated $36 billion—$12 billion more than the Commission's proposal—and would cover only about half the currently uninsured. At least 14.4 million Americans would still lack health insurance from any source.

Figure B-1 Comparison of Cost, by Health Insurance Options

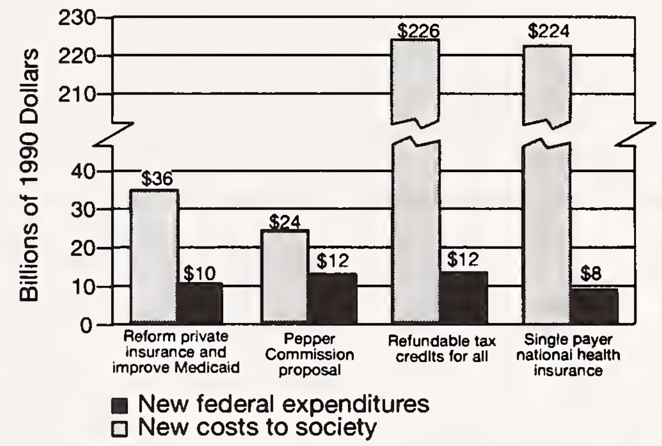
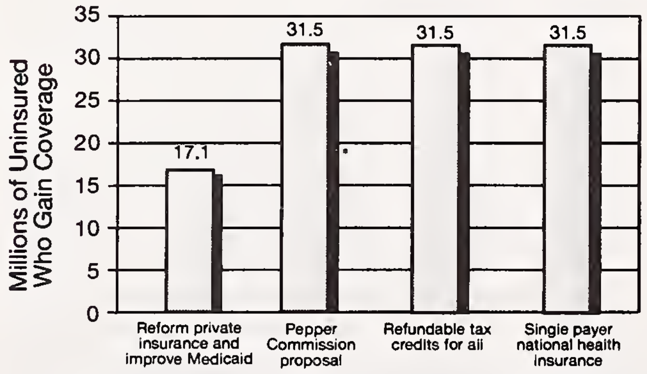


Figure B-2 Comparison of Coverage, by Health Insurance Options



NOTE: 31.5 million people under age 65 now lack health insurance

The limited impact of this proposal on coverage reflects the fact that even subsidies to people with incomes up to twice the poverty level leave insurance beyond the means of many who are now uninsured. Subsidies may not be sufficient to make coverage affordable for the near-poor, and people with incomes above twice the poverty level would get no help with insurance costs.[2] A family of three with an income of about $20,000 (twice the poverty standard), for example, could face insurance costs exceeding 10 percent of their income.

The new federal costs are relatively high because coverage would be extended to many workers and their families who could obtain job-based coverage if their employers provided it. More than half the uninsured are workers or in families of workers with family incomes below twice the poverty level.

This approach also raises the concern that employers might drop the coverage they provide if their employees could obtain it elsewhere. The more generous the subsidy, the more likely that behavior becomes. If low-income people who now have job-based insurance were to use Medicaid or the subsidies, federal costs could increase by another $15.6 billion.[3]

The net new cost to society of covering about 17 million of the uninsured (the sum of the net costs to the federal government, and savings to state governments and individuals) would be $10 billion, or $585 per newly insured person.[4, 5] This compares with net new costs to society of $12 billion under the Commission recommendations for almost 32 million uninsured ($381 per newly insured person).

The Commission rejected this approach for three reasons. First, it would not ensure adequate health insurance for all Americans. Half of today's uninsured would remain uninsured, and the underinsured would not be helped at all.

Second, because the federal government would absorb the full costs for low-income workers, taxpayers would have to pay substantially more than the job-based approach the Commission recommends. Further, it threatens to unravel the coverage employers now provide—shifting costs from employers to taxpayers.

Third, without universal coverage it would be impossible either to eliminate uncompensated care or to stop the cost shifting from those without coverage to those with it. Larger employers, who pay for much of this cost shifting, would not benefit from this proposal.

Replacing the Current System

The Commission considered replacing the job-based connection to health insurance—that is, replacing the mechanism by which 75 percent of all workers and their dependents now obtain health insurance—with two very different approaches to national health insurance. These were a refundable tax credit provided to everyone for the purchase of private health insurance and a single-payer, federally run national health insurance system.

Table B-1 Options for Health Insurance Coverage: Costs and Distribution

(In Billions of 1990 Dollars)

Option	Net New Federal Expenditure	Net New State and Local Expenditures	Net New Private Expenditures	Net New Health Costs to Society	New Costs to Society per Newly Insured (In dollars)
I. Expanded Medicaid plus subsidies for private insurance	$36	($4)	($22)	$10	$585
Americans without health insurance = 14.4 million					
II. Pepper Commission Proposal	24	(7)	(5)*	12	381
Americans without health insurance = 0					
III. Refundable Tax Credit for all Americans	226	(7)	(207)	12	381
Americans without health insurance = 0					
IV. Single payer national health insurance	224	(7)	(209)	8	254
Americans without health insurance = 0					

* Employers who now provide health insurance will save $12.8 billion. Employers who now do not provide health insurance will spend an additional $27.5 billion. Individuals will save $19.3 billion in out-of-pocket and premium expenses.

SOURCE: Staff estimates reviewed by John Sheils of Lewin/ICF and Kenneth Thorpe of Harvard School of Public Health.

The particular refundable credit approach analyzed by the Commission would entitle all Americans (including those who are poor but not eligible for Medicaid) to a refundable tax credit toward the purchase of a qualified health insurance plan. Except for the poor, tax credits would be valued at 80 percent of the average cost of health insurance in a particular geographic area. For the poor, the credit would be worth 100 percent of the average cost of health insurance. The health insurance would have to meet specific standards, including a minimum package of benefits. The insurers would have to participate in periodic open enrollments and premiums would have to be the same for all enrollees in the community.

The single-payer national health insurance (NHI) plan considered by the Commission would pay for the health care of all Americans. While private insurers might be able to participate in the processing of the claims filed, private insurance for publicly covered benefits would be prohibited. Individuals would be free to choose among health care providers, but the federal government would determine provider payment rates. Payment methods could entail area budgets for hospitals and negotiated fee schedules for physicians and other providers, subject to budgets.

The advantage of replacing the current system with a new national health insurance program of either type is that it would treat all Americans the same way. Insurance would not have to change when employment changes. The government-run system, in particular, could be administratively straightforward. Essentially everyone would have an identical health insurance card. The system would save both the administrative costs of duplicative insurance companies, and the marketing costs and profits of insurance companies. By contrast, the tax credit approach could increase administrative costs, as insurance shifted from a job-based to an individual market.

Furthermore, inherent in either approach are mechanisms aimed at containing health care expenditures. The tax credit approach would rely on price competition among insurers and providers to encourage cost consciousness among consumers. Shopping for the lowest health insurance price, it is argued, would encourage insurers and providers to work together on ways to reduce health care costs and, consequently, their premiums.

But relying on this approach as the sole mechanism for cost containment means depending on a complicated chain of events, which might not occur. Educating consumers to make effective choices is not a simple task, and their actual choice may reflect aspects of the insurance that have little to do with the health plan's efficiency. U.S. experience to date shows that employers—who have entire departments of experts and larger checkbooks than individuals—are only beginning to manage their health plans in ways likely to contain costs. The tax credit approach would eliminate their role and their efforts from the system. It is highly uncertain that individuals would do a better job than employers in choosing the most cost-effective plan. Helping consumers make the choice—and preventing insurers from competing for good risks—would require substantial government involvement.

The government approach would control health care expenditures through government determination or negotiation of payments for care. Relying solely on government action to contain costs puts considerable pressure on a single system of payment. Critics contend that political pressures to expand benefits and improve reimbursement, combined with difficulty in controlling service use, would constrain the government's ability to check health care expenditures. The expansion of Medicare is often cited as an example. Government, too, is only now learning to control its costs. The experience of other nations shows that controlling costs through government oversight or determination of payment is difficult but can be accomplished.

Either approach would be highly disruptive to current insurance arrangements and very costly to the federal government. It would require dismantling most of the social and economic relationships that now exist for health care and that still assure most people adequate protection. It would also require a tremendous increase in expenditures by the federal treasury. Net new federal expenditures for the refundable tax credit option would be $226 billion. New health costs to society for this approach would be $12 billion ($381 per newly insured person). Net new federal expenditures for the single-payer national health plan would total $224 billion. Net new costs to society for this approach would be $8 billion ($254 per newly insured person)—a reflection of the reduction in administrative costs that this option would allow.

The Commission decided against both national health insurance approaches because of the major disruption involved, the shift in financing from employers to taxpayers, and the belief that effective action can be more readily accomplished by building upon the current system. Furthermore, in the Commission's view, neither approach is necessary to achieve cost containment, since the best elements of competition and government payment controls can be incorporated in a combination job-based and public system.

LONG-TERM CARE

The options that the Commission considered to reach its long-term care goals can be classified into three broad categories. These were (1) providing government coverage to the low-income population and promoting private insurance for the better-off; (2) providing comprehensive social insurance for all long-term care services (at home and in nursing homes), relying on private insurance to finance cost sharing requirements; and (3) providing limited social insurance for nursing home care—for example, by trading some current Medicare coverage (accepting higher deductibles) for limited nursing home care, or covering only the early part ("front-end") or last part ("back-end") of nursing home stays.[6] Under the third approach, services not covered by social insurance would be subject to a combination of private insurance and government assistance for the low-income population. The Commission evaluated the adequacy of the protection these options provided, as well as their costs to the taxpayer.

Expanding and Improving Medicaid and Promoting Private Long-Term Care Insurance

This strategy, which (relative to other options) minimizes the government's role as payer, would expand Medicaid coverage for home and community-based care for the poor and near-poor. It would also enhance Medicaid financial protection for single nursing home users. Moreover, it would subsidize private long-term care insurance for low- and middle-income people.

Compared with current policy, this approach would improve people's protection in several ways. Publicly financed home and community-based care would not only provide support that low-income disabled people now lack, but also enhance their ability to live independently in the community. For those who need nursing home care, the proposal would fill some current gaps. Medicaid's financial protection is not now uniform across states. In some states, for example, individuals whose incomes fall below the price of nursing home care but are above the established level for Medicaid eligibility are not allowed to "spend down." These people may have to remain in the community even though they need institutional care.

Furthermore, although the Medicare Catastrophic Coverage Act of 1988 (in provisions that have been retained) raised the level of assets that are protected for the noninstitutionalized spouse, no comparable asset protection was provided to single nursing home residents. These people must spend down their life's savings to $2,000 before they receive any benefits.

This option would also address barriers that may now limit private long-term care insurance. Ambiguities in the tax treatment of long-term care insurance premiums have been viewed as inhibitors to market growth, particularly the employer-based market. Modifying the tax code so that it would treat private long-term care insurance like health insurance would help insurers market policies to individuals. It would also encourage employers to offer and perhaps contribute to group plans, thus making the purchase of a policy more accessible and affordable to more people and at younger ages. Subsidies could further reduce costs to both employers and individuals. Some states, for example, are exploring subsidies for the purchase of private long-term care insurance by waiving Medicaid asset depletion requirements for people who have purchased a qualified policy. Alternatively, subsidies could take the more traditional form of refundable tax credits.

The specific proposal the Commission evaluated has the following elements.

Home and Community-Based Care—Eligibility for home and community-based services under Medicaid would be improved by replacing Medicaid's optional personal care program and the waiver programs with a mandatory program, creating uniformity across states. The income eligibility criterion would be raised to 200 percent of the poverty level, but no asset test would be applied. To be eligible for benefits, individuals would have to be severely disabled as measured by a demonstrated need for personal assistance with impairments in three or more activities of daily living (ADLs) or the presence of cognitive impairment. The service package would be determined by a case manager who, working together with the family (where available), would allocate the appropriate type and amount of services. Beneficiaries with incomes between 100 percent and 200 percent of the poverty level would be required to contribute to the cost of their care.

Nursing Home Improvements—All states would be required to establish a medically needy program for Medicaid-financed nursing home care. This would allow all persons with incomes below the costs of institutional care but above 200 percent of the poverty level (about equal to 300 percent of Supplemental Security Income) to spend down their incomes to Medicaid eligibility. In addition, single persons who qualify for the nursing home benefit would be allowed to keep up to $12,000 in nonhousing assets.

Government Promotion of Private Long-Term Care Insurance—Government would pursue two strategies to expand private health insurance. First, it would clarify the federal tax code so that the long-term care insurance premiums paid and the benefits received are treated like health insurance premiums and benefits. In addition, the government would subsidize the purchase of private long-term care insurance through a 20 percent tax credit. This credit would be targeted at the low- and middle-income population. Specifically, individuals with $25,000 or less and couples with $40,000 or less would qualify. Above these thresholds, the credit would be reduced by one percentage point for each $1,000 increase in adjusted gross income, so that the credit would be phased out for individuals with $45,000 and couples with $60,000 or more.

Table B–2 shows how these measures would provide people protection, both today and in the future. If this program were implemented today, about half the elderly population and 30 percent of those under 65 would qualify for home care protection through the Medicaid program, on the basis of their incomes (less than 200 percent of poverty). The new costs of home care provisions to federal and state governments (shared through Medicaid) would be about $11.6 billion—$7.3 billion for the elderly and $4.3 billion for the nonelderly.[7] Nursing home improvements would cost an estimated $1.1 billion. Private insurance would take time to expand, even with increased government support. Its effects must therefore be examined over time. Furthermore, given uncertainties about the growth of private insurance, it is appropriate to consider a range of possible effects in the future, rather than a single estimate. By the year 2000, private insurance could reach from 8 percent to 20 percent of the elderly and, by the year 2018, 26 percent to 50 percent of the elderly.[8] The combination of private insurance and Medicaid in 2018 could reach between 61 percent and 85 percent of the elderly.

Costs to the federal government of private insurance expansion would, of course, depend on how many people use the subsidies provided. Estimated costs range from $1.4 billion to $2.6 billion in the year 2018, *exclusive* of diminished federal revenues associated with preferential tax treatment.

The Commission recognizes the value of Medicaid improvements and the growth of private insurance. Nevertheless, it concluded that this approach would leave large segments of the population still at risk of inadequate protection or excessive financial burden, now and into the future, should they need long-term care.

Table B-2 Public Costs and Coverage of Long-Term Care Option to Improve Medicaid and Promote Private Insurance in Years 1990, 2000, 2018

Option/Year	New Public Costs (All Ages) (billions of 1989 $)	New Public Costs for Elderly (billions of 1989 $)	Percentage of Elderly Protected (Unprotected)
1990			
Medicaid			
Home care	$11.6	$7.3	51% [a]
Nursing home	1.1	1.0	38 [b]
Private insurance	0.3–0.6	—	6–10 [c]
Combination	—	—	58–62
Proportion unprotected	—	—	(38–42)
2000			
Medicaid			
Home care	14.6	9.1	44 [a]
Nursing home	2.0	1.8	35 [b]
Private insurance	0.5–1.1	—	8–20 [c]
Combination	—	—	57–69
Proportion unprotected	—		(31–43)
2018			
Medicaid			
Home care	19.5	12.2	22
Nursing home	2.6	2.3	32
Private insurance	1.4–2.6	—	26–50
Combination	—	—	61–85
Proportion unprotected	—	—	(15–39)

[a] Percent of elderly who satisfy income eligibility requirements.

[b] Percent of elderly whose assets would be fully protected.

[c] Percent of elderly expected to purchase private insurance.

SOURCE: Lewin/ICF estimates, based on Brookings/ICF Long-Term Care Financing Model.

Because private insurance will take time to grow, even in the year 2000, the Medicaid program would continue to be the primary source of protection for the elderly under this option. (Data limitations make it necessary to focus analysis on the population over age 65.) Through the year 2000, the incomes of nearly half the elderly would be too high to qualify for expanded coverage at home. Fewer than two out of five elderly people would have assets fully protected by the enhanced nursing home benefits.

Over the long term, the Commission sees considerable uncertainty in the scope of private long-term care insurance coverage and considerable certainty that serious gaps would remain. Depending on assumptions about individual and employer behavior, predictions range from about a quarter to almost half the population with coverage over the next 30 years. Building universal coverage on a private market strategy means waiting to see what will happen, with little security that the broadest coverage levels will be reached or that those who purchase coverage will have adequate benefits. The benefits included here leave gaps that could impoverish many nursing home users. Home care coverage in particular is limited; even people with nursing home coverage may be unable to afford the deductible without exhausting their assets.

Alongside enormous uncertainty, the Commission believes that reliance on private insurance implies a number of certainties, which are equally disturbing. Even optimistic assumptions about coverage 30 years from now indicate that half the elderly population will not have private insurance. Taking Medicaid into account, from 15 percent to 39 percent of the elderly are estimated to lack coverage in the year 2018. Given widespread dissatisfaction with a health care system that excludes 15 percent of Americans and a pension system that leaves out half of all workers, the Commission questions the desirability of following a similar strategy for long-term care.

The Commission's assessment of problems in our health care system showed that targeting government assistance to low-income people and relying on private insurance for the rest would find low- or modest-income workers the most likely to be without protection; that the public program for the lower-income population would probably receive inadequate financing, since the better-off would derive little or no benefit from it; and that the administrative costs of relying on multiple insurers would be high. The Commission therefore rejected an option that would repeat the nation's health care experience in long-term care.

Social Insurance for Long-Term Care

The Commission also explored an approach whereby government would take primary responsibility for financing long-term care through a social insurance program for long-term care at home or in nursing homes. Private long-term care insurance would be encouraged to finance cost sharing requirements.

A comprehensive social insurance approach to financing long-term care would ensure that no one falls through the cracks, and would eliminate the two-tiered problem of access and quality. It would be the most effective way to spread the risk across large numbers of people (by having all participate through the tax system), thus reducing the costs to each person. Through such a large pool, government could absorb the costs of the currently disabled, who would not be covered by private insurance. Furthermore, a social insurance approach would relate payments to the ability to pay, which private insurance cannot. Finally, compared with a predominantly private system, a social insurance system would entail lower administrative costs.

The specific intervention the Commission explored has the following specifications.

Home and Community-Based Care—All severely disabled people who either require personal assistance with three or more ADLs or are cognitively impaired would be eligible for services, regardless of income. A case manager, working within a budget set by the federal government, would tailor services to the needs of each individual. Benefits would be designed to complement, rather than replace, care provided informally to the disabled person by family and friends. In addition, beneficiaries who can afford to contribute to the cost of their care would be required to do so. Copayments would be subsidized for persons with incomes below 200 percent of poverty.

Comprehensive Nursing Home Care—All severely disabled people, regardless of income, would be eligible for nursing home coverage after the first two months of care, during which individuals would be responsible for all costs. The federal government would then reimburse 80 percent of these costs. Beneficiaries would be responsible for the remaining costs, although there would be sliding scale subsidies for people with incomes below 200 percent of the poverty level.

This option would protect all Americans should they need long-term care—those who are now disabled as well as those who might become disabled—regardless of age or income. The new federal costs of this home care program would be $24 billion if fully implemented in 1990: $15 billion for the elderly and $9 billion for the population under age 65.[9] The nursing home coverage would require new public expenditures of $34 billion.[10]

A comprehensive social insurance approach would provide long-term care protection for all Americans, just as Medicare provides health insurance for the elderly. Seeing considerable merit in this approach, the Commission concluded it was essential to build an adequate home care system and to keep resources intact for severely disabled people at home. However, the Commission questioned the appropriateness of investing substantial public resources in protecting all nursing home use, since substantial public dollars would go toward preserving assets for people who never return to the community—including the wealthiest segment of the population. Given these concerns, the Commission sought alternative ways to provide a limited nursing home benefit.

Limited Coverage of Nursing Home Care—The Commission examined several specific options to provide limited protection for nursing home costs. Each option was assessed with particular regard to its capacity to alleviate financial burdens and prevent impoverishment, in the event of nursing home use. Table B–3 compares the costs and coverage under some of these options, relative to comprehensive nursing home coverage and the Commission recommendations.

Medicare Long-Term Care Option [11]—One way to limit both government expenditures and public support for elderly people who can afford to protect themselves would be to offer those over 65 an option to reduce their Medicare coverage for acute care in return for some limited nursing home protection. Specifically, an individual could opt for an increased Medicare deductible (Part B, perhaps in conjunction with Part A) in return for a nursing home benefit.

The Commission's analysis indicates that substantial increases in current Medicare deductibles would be required to fund even very restricted benefits. Coverage for the first year of a nursing home stay for example would probably require an increase in the Part B (physician services) deductible (now $75) to $1,000 and an increase in the Part A (hospital care) deductible (now $592) as well. People with higher incomes, who would be most able to afford these trade-offs, are unlikely to find it attractive since they could afford a more comprehensive long-term care policy through the private sector. Those most likely to choose this limited benefit initially would be people who already need long-term care but could not get private insurance. If these people choose the long-term care option, the group would start out with an adverse risk pool, leading to quickly escalating costs and discouraging others from participating. Finally, for low- and moderate-income individuals, this approach would require a difficult trade-off between higher financial burdens for health care services now covered and the new benefits provided.

Given its limitations, the Commission rejected this option.

Front-End Coverage—Another way to reduce public spending for nursing home care would be to limit the length of stay during which benefits would be provided. One approach is to provide coverage for the first part, or front end, of nursing home care. Although this strategy would help all nursing home users, it is designed primarily to keep resources intact for those who potentially return home after a nursing home stay. Slightly more than half of all nursing home entrants in a year stay fewer than six months; about half these "short-stayers" go home. Individuals who can leave the nursing home need to keep their resources intact so they can afford or maintain a reasonable standard of living once they go home.

In the alternative explored by the Commission, all people eligible for nursing home care would be enti-

Table B–3 Costs and Coverage of Nursing Home Users for Selected Proposals

Coverage	New Public Costs (All Ages) (In billions)	New Public Costs (Elderly Only) (In billions)	Elderly Entrants Covered (In millions)	Elderly Entrants Covered for Full Length of Stay (In millions)
Comprehensive (two-month deductible)	$34.0	$30.1	.8	None
Cover stays up to six months ("front-end")	9.8	8.7	1.2	.6
Cover whole stay after two years ("back-end")	15.4	13.6	.3	None
Pepper Commission	18.8			
Three-month "front-end"		6.0	1.2	.5
Full or partial protection after three months		11.0	.5	.4 [a]

[a] This is the number of entrants who stay beyond three months and who receive asset protection from that point on. For additional detail on coverage under the Pepper Commission plan, see Table 4–3.

SOURCE: Lewin/ICF estimates using the Brookings/ICF Long-Term Care Financing Model.

tled to full coverage for a period not to exceed six months per episode of care. All people entering nursing homes in a given year would benefit from this coverage at a new federal cost of $9.8 billion. Looking at the elderly, for whom better data are available, this would mean coverage for about 1.2 million nursing home entrants. For just over half of all entrants—more than 600,000 elderly—benefits would cover the entire stay.

The Commission sees considerable merit in nursing home protection directed at preserving resources for people with the potential to return home. Nonetheless, the Commission believes that, regardless of length of stay, no one needing nursing home care should be at risk of impoverishment. Limiting coverage to six months continues to leave people at risk. Without private insurance protection, costs of long stays would clearly be catastrophic. And, as noted above, private insurance will leave many inadequately protected. Particularly troublesome to the Commission are moderate-income people, for whom reliance on private long-term care insurance would impose significant financial burdens. Even with public coverage at the front end, premiums could absorb more than 5 percent of income for most of today's elderly.

Because time-limited public coverage would not allay people's fear of impoverishment from long nursing home stays, the Commission rejected this option as insufficient.

Back-End Coverage—An alternative approach to limited nursing home protection would concentrate benefits on the longest stayers. By limiting insurer liabilities, this approach might also make private insurance more affordable for the initial part of a stay. In the version of this approach analyzed by the Commission, individuals would be responsible for the cost of the first two years of nursing home care. After this exclusionary period, 80 percent of nursing home costs would be reimbursed for an unlimited period. Beneficiaries would be required to pay for the remaining 20 percent. As with other approaches, this cost sharing would be subsidized for beneficiaries with low incomes.

Such coverage would entail about $15.4 billion in new federal costs. It would protect the estimated 300,000 elderly people entering nursing homes whose stays exceed two years. Fewer nursing home entrants benefit from back-end than from front-end coverage. Yet costs for back-end are substantially higher because "long-stayers" account for almost half of all nursing home days in any given year.

The Commission sees merit in protection for long stays. It remains concerned, however, that coverage beginning only after two years leaves too many elderly nursing home entrants—about three-quarters each year—at risk of impoverishment. Two years in a nursing home cost nearly $60,000. Without private insurance, most nursing home entrants would exhaust their life's savings long before the benefit goes into effect. Individuals could obtain comprehensive coverage by purchasing private insurance to fill in the uncovered gap. However, as with front-end coverage, premiums for private insurance to supplement back-end coverage could exceed 5 percent of income for the most of today's elderly.

In the absence of extensive private insurance coverage, a back-end benefit would concentrate public resources on nursing home users who are sufficiently well-off to still have resources to protect after a two-year stay. Even after accounting for some expanded private insurance coverage, 70 percent of elderly beneficiaries of a back-end benefit would have assets of $50,000 or more.

The Commission thought the back-end approach inadequate because it still left too many people at risk of impoverishment.

Commission's Nursing Home Coverage—After reviewing alternative approaches, the Commission concludes that a limited nursing home benefit must have two components:

- Social insurance to keep resources intact for people with the potential to return home after a short nursing home stay;
- Protection of the life savings of moderate income people, no matter how long they stay in a nursing home.

To accommodate this combination of front-end and back-end coverage and keep expenditures in reasonable bounds, the Commission recommendations limit front-end protection to stays of less than three (not six) months. Such an approach would cover more than 80 percent of elderly people who stay in nursing homes fewer than six months. The Commission's back-end benefit would provide a floor of protection against impoverishment that would leave intact the life savings of three out of five elderly people.

Notes to Appendix B

1. Data presented in this section were prepared by Commission staff with assistance from John Sheils of Lewin/ICF, Inc. and Kenneth Thorpe of the Harvard School of Public Health.

2. Cost and coverage estimates are based on the assumption that all individuals with incomes below 100 percent of poverty would participate, since they get full coverage. For the near-poor, estimates assume that a 50 percent subsidy would induce participation by 50 percent of the eligible population without job-based coverage. Although the proposed option would vary the subsidy with income—from a high of 75 percent of the premium for people with income between 100 and 125 percent of poverty to zero at 200 percent of poverty—the weighted average subsidy for the full population is about 50 percent of premium.

3. Estimate assumes 100 percent participation by the poor, 50 percent participation by the near-poor.

4. Under this option (as under the Commission's recommendations), states would contribute what they currently spend on the specified set of health services through their Medicaid programs, increased annually for general inflation. Insuring the uninsured under the federal program would save state and local governments some of their uncompensated public hospital expenditures and some of their other expenditures on the medically indigent. On net, this is estimated to result in savings of about $4 billion.

5. Although individuals encouraged to purchase health insurance would incur new expenses, the poor and near-poor who now purchase private health insurance as individuals (not job-based) or would have faced health care expenses without health insurance would save a tremendous amount. The net savings to individuals would be $22 billion. Since millions of Americans would still be without adequate coverage, the savings are not offset by substantial new premium payments associated with universal coverage that requires individual contributions.

6. Data presented in this section are from the updated Brookings/ICF Long-Term Care Financing Model and were prepared for the Commission by David Kennell and Lisa Alecxih of Lewin/ICF, Inc. An explanation of the model as used to estimate the Commission's recommendations is presented in the "Assumptions Used to Estimate Costs for the Long-Term Care Recommendations."

7. Except for its means-tested eligibility (limited to people with incomes below 200 percent of poverty), this home care benefit is similar to the benefit the Commission recommends. Its costs are lower than the costs of the Pepper Commission home care recommendations because fewer people are eligible, due to income requirements; a lower proportion of eligible people are likely to participate because it is a welfare program; and the additional cost per user is lower, since a larger proportion of beneficiaries already receive public benefits. These factors explain 43 percent, 25 percent, and 32 percent, respectively, of the cost difference between the two proposals.

8. The long-term care insurance policy used for this analysis covered four years of nursing home care after a 100 day deductible period. The policy paid $50 per day and was partially indexed for inflation at 5 percent of the purchased benefit per year up to age 85. Home care benefits under the policy were dependent on the number of nursing home days received. Today, premiums for individuals policies like these would be $236 if under age 55, $583 at age 65, and $1,255 at age 75. If purchased through employment, premiums would be about 80 percent of these amounts.

   Estimates of who would have long-term care insurance were based on the updated Brookings/ICF Long-Term Care Financing Model. The assumptions about the decision to purchase, lapse rates, the growth in employer sponsorship, as well as the policy and premiums are described in Chapter 3, endnotes 73 and 74. The microsimulation model is described in more detail in Appendix E.

   The range of estimates reported reflect slight variations in these assumptions. While the tax credits have a very small impact on the effective price of insurance, and therefore on the price relative to income, the tax credit may alter preferences for long-term care insurance. This is reflected in the upper bound of the range of estimates.

   These estimates assume that the tax code has been clarified so that long-term care insurance receives the same tax treatment as other employee benefits such as health insurance.

9. This is the home care proposal adopted by the Commission.

10. These estimates were developed using the updated Brookings/ICF Long-Term Care Financing Model, based on assumptions as described for the estimates of the Commission recommendations. Estimates for comprehensive coverage assume a 30 percent increase in demand for nursing home care.

11. For a more detailed discussion of this approach, see staff analysis in the Supplementary Volume.

Appendix C

Cost Impacts for Large and Small Businesses

Large and small firms now differ considerably in their health insurance offerings and would be treated differently by the Commission recommendations. The impact of the recommendations is shown here for firms with 100 or more workers and for those with fewer than 100 workers.

Larger firms are more likely to provide health insurance, and therefore are more apt than smaller firms to benefit from the Commission's recommendations. On net—after new expenditures and savings are taken into account—large employers would save $5.6 billion—5.8 percent of their health care spending.

The direct cost of requiring larger employers to contribute to the cost of insuring all of their employees would increase large employer health expenditures by $11 billion (see Table C–1). About 11.4 million workers and about 5 million dependents would become covered under this provision. Of the newly covered workers, about 5.6 million would be part-time workers excluded under an existing plan.

The cost of conforming to the minimum benefits and premium sharing standards will be about $3.3 billion. About 14 percent of all large firms that currently offer insurance would be affected by the minimum benefit and premium sharing provisions.

However, these expenditures would be offset by a number of savings. Larger employers would save about $7 billion due to reduced uncompensated care and cost shifting from Medicaid, and more than $13 billion as workers whom they now cover as dependents obtain coverage from their own employers. Finally, some employers could reduce their health spending by obtaining coverage for their employees from the public plan by paying a share of payroll. At a payroll contribution rate of 7 percent, about 6,100 large employers (7.5 percent) would find it to their advantage to rely on the public plan. Large employers who rely on the public plan would reduce their health spending by about $1 billion.

Table C–1 Impact of Commission Plan on Employer Health Insurance Costs in All Firms of 100 or More Workers

(In Billions, 1990)

	Employer Costs
Current employer expenditures for health insurance	$93.5
Change in costs under employer "provide or contribute" plan	
Cost of insuring all workers and dependents currently not insured by large firms	11.0
Part-time workers excluded from existing plan	3.4
Persons in firms that currently do not offer insurance	7.6
Impact of minimum benefit and premium standards	3.3
Employer premium share increase	2.7
Improvement in plan provisions	0.6
Working spouses and dependents shifted to other employer plans	(13.3)
7.0 percent cap on employer costs	(1.0)
Reduction in uncompensated care cost shift	(7.0)
Total employer plan costs	$86.5
Change in employer plan costs	(7.0)
Change in tax expenditures	1.4
Net after-tax change in employer costs	(5.6)
Percent change in employer health insurance expenditures	(5.8%)

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model.

On net, these changes would reduce large employers' health expenditures roughly $7 billion. Taking into account higher tax payments as health expenditures drop, their spending would be reduced $5.6 billion, or 5.8 percent.

Since smaller firms are less likely than larger employers to now provide health insurance, their costs would increase. Table C–2 illustrates the impact on small employers under the incentives the Commission recommends and under requirements, if incentives prove insufficient.

If all smaller employers were to offer insurance in response to incentives, costs would increase $18.8 billion, after taxes, or 1.8 percent of payroll. For smaller employers, the cost of covering previously uninsured persons ($34.7 billion) and expanding benefits to meet the minimum standard ($5.9 billion) would total $40.6 billion. This increase would be offset for five years by a 40 percent refundable tax credit for employers with fewer than 25 workers and an average annual payroll of $18,000 per worker amounting to $5.8 billion; by $7.6 billion in lower taxes (including use of the new opportunity to deduct full premium costs); and by $8.4 billion in reduced responsibility for covering workers of other employers and for uncompensated care.

The estimated 28.6 million workers in small firms who are not covered through their own jobs—some 3.7 million of whom work part time—would receive job-based coverage under these provisions. Another 11.7 million dependents would also get job-based coverage. In addition, the Commission's plan would affect some existing small employer plans that fall short of the plan's minimum benefit and premium sharing standards. About 25 percent of all small firms that now offer insurance would fail to meet the minimum benefits and premium sharing provisions of the Commission's plan.

If small employers were to become subject to the requirement to provide private or public health insurance, their after tax health expenditures would increase by about $20.6 billion, a 2.1 percent increase in their cost of labor. The cost of requiring employers to contribute to insuring all workers and dependents not now insured would be about $30.5 billion (see Table C–2). (This cost assumes a cap on employer payments for health insurance at 7 percent of payroll, an example of the contribution rate to obtain public coverage.) The cost of the minimum benefits standard and premium sharing requirements would be about $5.9 billion. Estimated total new costs are therefore $36.4 billion.

Table C–2 Impact of Commission Plan on Employer Health Insurance Costs in Firms With Under 100 Workers

(In Billions, 1990)

Costs	All Firms Voluntarily Provide Insurance	Employer Provide or Contribute Program
Current employer expenditures for health insurance	$31.8	$31.8
Change in costs under employer "provide or contribute" plan		
Cost of insuring all workers and dependents currently not insured by small firms	34.7	30.5 [a]
Part-time workers excluded under existing plans	1.6	1.4
Workers and dependents in firms that currently do not insure	33.1	29.1
40 percent tax credit for firms with less than 25 workers and average payroll below $18,000 per worker	(5.8)	N/A
Impact of minimum benefit and premium standards	5.9	5.9
Employer premium share increase	3.8	3.8
Improvement in plan provisions	2.1	2.1
Working spouses and dependents shifted to other employer plans	(5.9)	(5.9)
7.0 percent cap on employer costs for firms that now insure	N/A	(0.5)
Reduction in uncompensated care cost shift	(2.5)	(2.5)
Total employer plan costs	$58.2	$59.3
Change in employer plan costs	$26.4	$27.5
Income tax savings [b]	(7.6)	(6.9)
Net change in employer costs	$18.8	$20.6
Change in employer costs as a percent of payroll	1.8%	2.1%

N/A = not applicable.

[a] Reflects the 7.0 percent cap on health expenditures as a percentage of payroll.

[b] Employers who qualify for the tax credit are permitted to deduct the full amount of health insurance premiums.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model.

These costs would be offset by savings of about $15.8 billion. Firms would save $5.9 billion as working spouses and dependents obtain coverage through their own employers, and $2.5 billion in reduced payments for uncompensated care. In addition, some employers could reduce their health spending by covering their employees under the public plan through the payroll contribution, lowering their costs by about $0.5 billion. Finally, higher health expenditures are offset by lower tax payments ($6.9 billion), including reductions due to the new opportunity to deduct full premium costs. The net increase in small employer benefit payments would be $20.6 billion (see Table C–2).

Appendix D

Assumptions Used to Estimate Costs for Health Care Recommendations

Estimates of the cost and impacts of the Commission's plan were developed using the most recent data available on health care costs and employer health plans.[1] Most of these estimates were produced using the Health Benefits Simulation Model (HBSM) developed by Lewin/ICF. The methodology and assumptions used to develop these estimates are described below. The discussion is organized into the following six sections:

- The Health Benefits Simulation Model
- Behavior and Impacts
- Employer Tax Credit
- Nonworker Coverage
- Premium and Cost Sharing Subsidies for Workers
- Utilization Response

THE HEALTH BENEFITS SIMULATION MODEL

The Health Benefits Simulation Model is a microsimulation model of health insurance coverage, health services utilization, and sources of payments for health care.[2] The model is based on several data sources. Among these are the 1980 National Medical Care Utilization and Expenditures Survey (NMCUES); the March 1988 Current Population Survey (CPS); the National Health Interview Survey (NHIS) data for 1980 through 1986; the National Health Accounts (NHA) data; and the Lewin/ICF Employer Health Plan Survey.

The primary data source used in the model is the 1980 NMCUES data, which have been "aged" to be representative of the population and health expenditures in 1990. NMCUES is a representative sample of persons in the United States. It provides information on family income; employment; family structure; sources of health insurance; utilization and expenditures by type of health care service (inpatient, outpatient, and so forth); and sources of payment (insurance, out-of-pocket, and so forth). These data were aged so that they are representative of the levels of income, population, insurance, and employment as reported in the 1988 CPS data; utilization of health services as reported in the NHIS data; and health expenditures as estimated in the NHA data.

The model was used to estimate the number of persons potentially affected by various components of the Commission's proposal, as well as the number of eligible persons who will enroll based upon observed patterns of enrollment behavior in existing public and private insurance programs. In addition, the model was used to estimate the increase in utilization that will occur as coverage is extended to previously uninsured persons. The model was then used to estimate program costs based on the household health expenditures data using the reimbursement and cost sharing rules of the Commission. The model was also used to estimate savings realized by current payers of health care benefits (such as family out-of-pocket, county hospitals, and charity care) as services previously paid by these sources become covered under the Commission's proposal.

The impact of the Commission's plan on employers and the likely employer responses to various tax incentive proposals were incorporated in the model. The analysis was based largely on a Lewin/ICF survey of employers in 1986, which provides information on (1) the number of persons offering health insurance; (2) characteristics of those persons' health plans; and (3) firm size, payroll, and revenues. These data were used to analyze the impact of (1) the number of employees in firms that fall short of various minimum benefits standards, (2) the number of workers eligible for various tax credits, and (3) the number of workers in firms that face an incentive to participate in the public plan rather than offering insurance to their employees. Each worker in the aged NMCUES data was assigned to one of 850 employers in the employer survey to estimate the impact of employer behavior on worker and dependent coverage.

The microsimulation approach permits aggregated estimates of program impacts while also providing information on the distribution of these impacts across socioeconomic groups. Because the model is based on a representative sample of the population, it produces aggregate estimates of the impact of policy proposals on total number of persons affected, aggregate health spending, and program costs. However, because the model developed these estimates on the basis of analyses performed on an individual-by-individual basis, the model permits estimates of the impact of these policies on various socioeconomic groups. Moreover, the microsimulation approach permits modeling of program rules which vary with individual circumstances (for example, Medicaid income eligibility rules and Medicare secondary payer rules) that cannot be modeled well with more aggregative approaches.

BEHAVIOR AND IMPACTS

Under the Commission's provide or contribute plan, employers would be required either to purchase private insurance or purchase public coverage through a contribution, defined as a percentage of payroll.

The Decision to Purchase Insurance or Contribute to the Public Plan

This analysis assumes that the employer's response will be to choose the course which minimizes its costs. Thus, employers are assumed to compare the private insurance premium to the contribution for public coverage and to choose whichever approach is least costly. In addition, it is assumed that the employer will make separate decisions for part-time and full-time workers.

HBSM simulated these decisions using the estimated average payroll for employees in each worker's place of employment. The employer's average contribution per worker under the proposal was estimated by multiplying the estimated average employee earnings by a 7 percent rate. Current data indicate that rate is consistent with the Commission's recommendations to distribute the newly insured between public and private plans. The model then compares this average contribution per employee to the employer share of the average premium payment per employee to determine whether the employer is better off purchasing insurance or paying the contribution. The employer's share of average premium payments per newly insured employee is estimated at $1,050 in 1990. This analysis entailed the following specific assumptions.

- Employers who now offer insurance but exclude part-time workers from the plan will choose to cover part-time workers who are employed for 20 or fewer hours per week through the public plan. (It is assumed that the contribution on part-time workers will generally be less costly than providing insurance.)
- Employers who currently offer health insurance will shift from private to public coverage in instances where total contributions for the firm would be less than total plan premium payments if they continued private health insurance.
- Employers who do not currently offer health insurance will purchase private health insurance coverage for full-time workers only in cases where the cost of purchasing this coverage for their work force is less than the cost of paying the contribution.
- Employers who do not currently offer health insurance will not purchase private insurance for part-time workers employed for 20 or fewer hours per week regardless of whether they decide to do so for full-time workers, and will pay the contributions to obtain public coverage for part-time employees.

Impact of Minimum Benefit Standards

All employers who decide to purchase private insurance are assumed to offer at least the minimum standard benefits package required by the Commission. Firms that currently do not offer insurance are assumed to offer insurance which conforms exactly to the Commission's minimum benefits package. Firms that currently provide coverage in excess of the minimum standard are assumed to continue to offer these benefits. Firms that offer benefits below the minimum standard are assumed to improve coverage to the minimum allowable level.

Estimates of the number of workers in plans that fall below the minimum benefits standard are based upon the Lewin/ICF Employer Health Plan Survey data. As discussed above, each insured worker is assigned to one of the employer plans in the health insurance survey. These data provide information on the coverage and cost sharing provisions of each health plan used to estimate the number of workers in plans that offer benefits below the actuarial value of the Commission's minimum benefits package. If a worker is assigned to a plan that has a net actuarial value smaller than the minimum standard, the plan is modified as follows.[3]

- The share of the total plan premium paid by the employer is increased until the employer premium payment is equal to 80 percent of the actuarial value of the minimum standard plan.
- If, after this adjustment, the employer is paying

100 percent of the costs and the plan premium paid by the employer is still less than the net actuarial value of the minimum standard, the proportion of the individual's health expenditures paid by the plan is increased. The increase is equal to the ratio of the value of the minimum standard benefits to the value of the employer paid health plan premiums (calculated in the prior step). Premiums under the plan are adjusted by the same ratio.

Using this set of assumptions, estimates are that under the Commission requirements about 75 percent of the increase in costs of complying with the minimum benefits package would be attributed to increases in the employer premium share. Only about 25 percent of the costs would be attributed to increases in covered services or reductions in cost sharing.

Inter-Employer Equity

Under the Commission's proposal, employers are permitted to discontinue coverage for working dependent spouses, since they are required to obtain coverage from their own employer. The plan also permits employers to require that in cases where there are two working spouses, dependent children are to be allocated across the plans offered by the two workers' employers. This would be done using a random allocation process whereby all of a couple's dependents are assigned to one or the other employer's plan.

To model this provision, employers who currently offer insurance are assumed to minimize costs while maintaining existing levels of coverage. Specifically, it is assumed that all employers would exercise the option of having their employees' dependents obtain coverage under the dependent's employer plan. However, it is assumed that employers provide these dependents with wraparound coverage such that the level of coverage for dependents is equal to the coverage received under current policy.

Program Costs

HBSM estimates total costs under the employer plan or the public plan based on the covered services and cost sharing provisions in the recommendations. The model identifies the health care events for newly covered persons, including those imputed to newly insured persons, which are covered under the employer plan using the condition and type of service data reported in NMCUES. Health expenditures are assigned to the employer or public plan, based on the individual's employment status. Reimbursement is then computed on the basis of the cost sharing rules of the plan.

EMPLOYER TAX CREDIT

The Commission's proposal includes a refundable tax credit for small employers with low-income workers who provide insurance. The tax credit is available to firms with fewer than 25 employees with an average payroll of $18,000 per year or less. The tax credit would reimburse employers for 40 percent of the employer's cost of insurance benefits up to the Commission's minimum benefits standard.

The health plan data were used to estimate the number of firms that would potentially qualify for the credit. Specifically these data were used to estimate the number of firms with fewer than 25 employees where average payroll was less than $18,000 per year. These data also provided information on the number of firms qualifying for the credit who do and do not provide insurance under current policy.

It was assumed that all small employers who now provide insurance and qualify for the credit would participate. The amount of the credit was calculated directly from the employer health expenditure data provided in the file. (The credit was limited only to the portion of the health costs covered under the minimum benefits standard.)

Among qualifying firms that do not now offer insurance, several estimates were developed under alternative assumptions of the percentage of firms that respond by offering insurance. In the first set of estimates, which is the basis of the Commission's cost estimate, all qualifying employers were assumed to respond by offering insurance. This is a high range estimate because tax credits of this type which are implemented at the state level typically result in only very small increases in the number of firms offering insurance. The literature on these programs suggests that a 1.0 percent reduction in the cost of health insurance is associated with an increase in the number of insuring firms of between 0.2 percent and 0.6 percent.[4]

NONWORKER COVERAGE

The Commission's plan creates a public program to provide coverage to all nonworkers. The plan covers persons who are not employed at any time during the year and covers part-year workers during months in which they are not working. The benefits for nonworkers are, for the most part, the same as under the employer plan.

The plan reduces or eliminates premium contributions and cost sharing for low-income persons. No cost sharing or premium payments are required for persons with incomes below the poverty line. For persons with incomes between the poverty line and 200 percent of poverty, deductibles and coinsurance are determined on a sliding scale, with income and premium contributions limited to 3 percent of income. Persons with income above twice the poverty line face the full deductible and coinsurance amounts required under the minimum benefits standard, and pay the full amount of the premium. Eligibility and costs under these subsidies were estimated directly from the income and expenditure data used in HBSM.

Eligibility and subsidy levels are assumed to be determined on the basis of an individual's income during the prior year. This differs from the current Medicaid program, where eligibility is determined on the basis of individuals' incomes during the month they apply for assistance. If this monthly accounting process were used, the cost of the Commission's nonworker program would be about one-third greater than shown in the Commission's estimates. This occurs because many individuals with annual incomes above the poverty line will be below poverty in certain months of the year (periods of unemployment, for instance).

All persons with incomes below poverty were assumed to participate in the program, and half of persons with incomes between poverty and 200 percent of poverty were assumed to enroll.

Reimbursement under the public plan was assumed to reflect Medicare reimbursement principles. In the model, this provision was estimated by adjusting benefit costs under the public plan to reflect differences in reimbursement between Medicare and private plans for persons in similar age and sex groups. This provision also implies an increase in reimbursement for persons formerly covered under Medicaid. Estimates of the change in reimbursement for these individuals are based on an analysis of Medicaid and Medicare reimbursement levels for inpatient hospital and physicians' services in selected states.[5]

PREMIUM AND COST SHARING SUBSIDIES FOR WORKERS

The Commission's plan would pay all or part of premium and cost sharing expenses for low-income workers. For workers below the poverty line, all employee premium payments and cost sharing would be reimbursed by the government. For persons with incomes between the poverty line and 200 percent of poverty, the government would reimburse the individual for deductibles and coinsurance on a sliding scale with income, and limit premium payments to 3 percent of income. Workers would be subsidized only for cost sharing and premiums for services covered under the minimum benefits standard.

These subsidies could be administered as a refundable tax credit arranged through the employer. The subsidy amount would be determined on the basis of the workers' incomes during the months they are employed.

Estimates of these low-income worker subsidies were developed directly from the income and cost sharing data estimated in HBSM. All workers with incomes below the poverty line were assumed to participate. Approximately one-half of workers with incomes between the poverty line and 200 percent of poverty are projected to participate.

UTILIZATION RESPONSE

As insurance is extended to currently uninsured persons, their use of health care services is likely to increase. Use of covered services by those who become newly insured under the Commission's plan is assumed to rise to the levels reported by currently insured persons with similar characteristics. A change in service use was simulated only for those who were not covered by public or private plans before employer requirements. Use was not assumed to increase among the currently insured, even though cost sharing is liberalized for many employer plans.

Notes for Appendix D

1. Prepared by John Sheils, Lewin/ICF, Inc.

2. A detailed description of the model is provided in: Lewin/ICF, "The Health Benefits Simulation Model (HBSM), Technical Documentation," submitted to the Office of Research, Health Care Financing Administration, April 13, 1990.

3. Net actuarial value refers to the actuarial value of the plan's benefits multiplied by the proportion of the plan premium cost paid by the employer.

4. Articles on this topic include:

   —Charles E. Phelps, *Demand for Health Insurance: A Theoretical and Empirical Investigation* (Santa Monica, Calif.: RAND, 1973).

   —J.F. Long and F.A. Scott, "The Income Tax and Nonwage Compensation," *Review of Economics and Statistics,* 64(2) 1982:211–219.

   —A. Taylor and G. Wilensky, "The Effect of Tax Policies on Expenditures for Private Insurance," in Jack Meyer (ed.) *Market Reforms in Health Care* (Washington, D.C., American Enterprise Institute, 1983), 163–184.

   —M. Holmer, "Tax Policy and the Demand for Health Insurance," *Journal of Health Economics,* 3 (3) 1984:203–221.

   —F. Sloan and K. Adamche, "Taxation and the Growth of Nonwage Compensation," *Public Finance Quarterly,* 14 (2) April 1986:115–137.

5. Estimates provided by Kenneth Thorpe of the Harvard School of Public Health. See Thorpe et al., "Including the Poor: The Fiscal Impacts of Medicaid Expansion." *Journal of the American Medical Association* 261 (1989): 1003–1007.

Appendix E

Assumptions Used to Estimate Costs for Long-Term Care Recommendations

Estimates of the costs of the long-term care program proposed by the Pepper Commission were made using the Brookings/ICF Long-Term Care Financing Model.[1] This appendix discusses the methodology used in estimating the costs of the proposed program. The first section presents an overview of the model structure, the databases used in the model, and the model's underlying logic. The key relationships and behavioral parameters of the model are then discussed. The final section explains the implementation of the Commission's proposal within the model's framework.

OVERVIEW OF THE MODEL

The Brookings/ICF Long-Term Care Financing Model simulates the utilization and financing of both institutional and noninstitutional long-term care services for elderly families over the period 1986 to 2020. Institutional services include nursing home care provided by skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). Noninstitutional services include home health, homemaker, personal care, and meal preparation services. The model simulates the number of individuals receiving these services and the costs of these services as financed by various public and private sources.

The model was jointly developed by The Brookings Institution and Lewin/ICF in 1986. Significant funding for the components of the model was received from the U.S. Department of Labor, the President's Commission on Pension Policy, the American Council of Life Insurance, the Employee Benefits Research Institute, the Congressional Budget Office, and the assistant secretary for planning and evaluation of the U.S. Department of Health and Human Services. Lewin/ICF and The Brookings Institution staff made major revisions to the model in 1989 with the support and guidance of the assistant secretary for planning and evaluation, U.S. Department of Health and Human Services, and the Robert Wood Johnson Foundation.

The objective of the model is to simulate the effects of various financing and organizational reform options on future public and private expenditures for nursing home and home care. The model can be used to simulate long-term care financing assuming changes in private methods (such as increased purchase of private long-term care insurance) or new public financing programs. These simulations are greatly affected by the choice of assumptions about the economy (such as the rate of growth of the overall economy and nursing home prices) and individual behavior (such as rates of nursing home utilization and insurance purchase). Because of the uncertainty surrounding some of these events, the model is designed to facilitate use of alternative assumptions to show how sensitive the results are to the assumptions chosen.

The key advantage of this model over actuarial models is its ability to simulate the effects of various policy options on the distribution of benefits for different economic and demographic groups. For example, the model can be used to generate estimates of the effects of proposals on demographic groups, such as low-income unmarried women age 85 and over, who have few assets.

The model begins with a nationally representative sample of the adult population with a record for each person's age, sex, income, and other characteristics assembled from the sources described below. The model simulates life events for each individual in the sample population from 1986 to 2020, using a Monte Carlo simulation methodology.[2] The model first simulates future demographic characteristics, labor force participation, and income and assets of the elderly. It then simulates disability, admission to and use of nursing home and home care, and methods of financing long-term care services. The model uses national data and does not take into account regional, state, or local variations.

The current version of the model is a major revision of the model that was developed jointly by Lewin/ICF and The Brookings Institution in 1986. The model was revised in 1988–89 to incorporate data from a number of newly available data sources, including the 1982–84 National Long-Term Care Survey (NLTCS), the 1985 National Nursing Home

Survey (NNHS), the 1984 Survey of Income and Program Participation (Wave 4), and Medicaid and Medicare program data provided by the Health Care Financing Administration (HCFA).

The six major components of the model are described below. A flowchart of these components is shown in Figure E-1.

Population Database

The model uses demographic and income information from the May 1979 Current Population Survey (CPS) for a nationally representative sample of 28,000 adult individuals of all ages in 1979. This 1979 database was chosen because social security earnings histories for each individual in the sample were matched to the CPS data. This is the last time that the CPS data were matched to social security earnings histories.

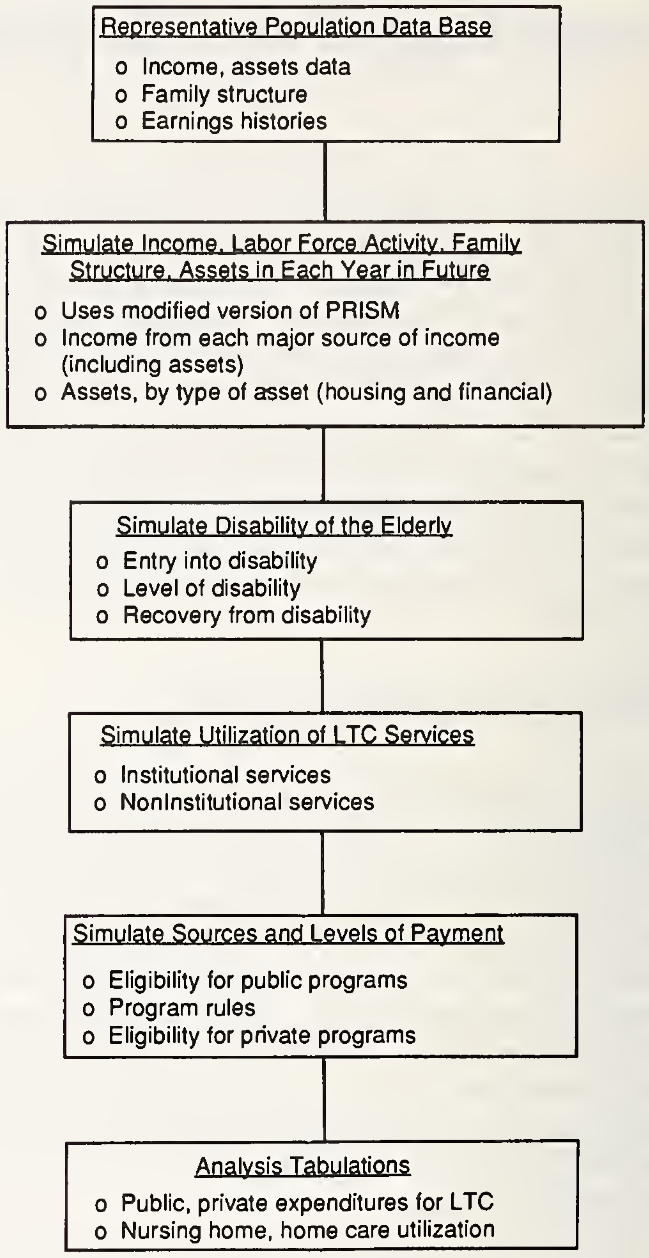
Income Simulator

The model then simulates demographic events such as mortality, marital status, labor force activity, income, and assets for each individual. The probabilities of the likelihood of marriage, work, and so forth for different demographic groups were estimated from matched CPS files and other sources. The aggregate probabilities of mortality are taken from Social Security Administration estimates. The macroeconomic assumptions underlying the simulations are generally those used in Alternative II-B of the 1989 Social Security Trustee's Report. These assumptions about future economic growth, inflation, unemployment, and wages greatly influence the model's results. These economic assumptions were selected in part because they are consistent with the demographic probabilities used in the model. Based on these assumptions, the model estimates retirement income from private sector defined benefit pension plans, public pension plans, social security, private sector defined contribution plans, Individual Retirement Accounts (IRAs), and Keoghs. The model also simulates the assets of elderly individuals, including the value of home equity, from the 1984 Panel of the Survey of Income and Program Participation (SIPP).

Disability of the Elderly

Using probabilities estimated from the 1982-84 NLTCS and the 1985 NNHS, this part of the model simulates the level of disability for persons age 65 and over. The model simulates the onset of disability, the level of disability, changes in disability, and recovery from disability.

Figure E-1 Brookings/ICF Long-Term Care Financing Model


Representative Population Data Base
o Income, assets data
o Family structure
o Earnings histories
Simulate Income, Labor Force Activity, Family Structure, Assets in Each Year in Future
o Uses modified version of PRISM
o Income from each major source of income (including assets)
o Assets, by type of asset (housing and financial)
Simulate Disability of the Elderly
o Entry into disability
o Level of disability
o Recovery from disability
Simulate Utilization of LTC Services
o Institutional services
o NonInstitutional services
Simulate Sources and Levels of Payment
o Eligibility for public programs
o Program rules
o Eligibility for private programs
Analysis Tabulations
o Public, private expenditures for LTC
o Nursing home, home care utilization

Utilization of Long-Term Care Services

This part of the model uses probabilities estimated from the 1982-84 NLTCS and the 1985 NNHS to simulate admission to and length of stay in a nursing home. For noninstitutionalized persons, the model also simulates the use and length of receipt of paid home care services using probabilities derived primarily from the 1982-84 NLTCS and Medicare program data. Many policy changes can affect the utilization of services. Changes in the utilization of services resulting from changes in delivery or financing of long-term care are implemented in this module.

Sources and Levels of Payment

The fifth component of the model simulates the sources of payment and the level of expenditures for each individual receiving institutional or noninstitutional long-term care services. The model incorporates current Medicare eligibility and coverage provisions (post-Medicare Catastrophic Coverage Act provisions) and a set of uniform assumptions about the Medicaid program, including spousal impoverishment protection. State Medicaid program variations are not modeled. Altering the characteristics of existing programs or adding new programs to this component of the model permits analysis of the impact of policy options on the financing of care and the economic impact of policy changes on various demographic groups.

Aggregate Expenditures and Utilization

The sixth part of the model accumulates Medicare, Medicaid, private expenditures, and utilization for each simulated individual for each year. The final output file from the model provides detailed information for individuals age 65 and older, for each year from 1986 to 2020, on individuals' age, sex, marital status, disability, sources and amounts of income, assets, and use of and payment sources for nursing home and home care services. This file is tabulated to show aggregate long-term care expenditures for various demographic groups and sources of financing.

SPECIFICATION OF KEY MODEL RELATIONSHIPS

Under current policy, four key factors and relationships have the largest influence on the level and distribution of long-term care expenditures over the 1986 to 2020 period. These four factors are:

- Income and assets of the elderly, which influence whether individuals are able to pay privately for long-term care or must rely on Medicaid. In general, if income and assets increase faster than prices, the ability of the elderly to pay privately will increase.
- The level and severity of disability, which determines the size of the disabled population and the average number of years of disability prior to death. Whether disability rates will decrease as mortality rates decline will have a large impact on future long-term care expenditures.
- The likelihood of nursing home entry, which influences long-term care expenditures. If individuals use nursing homes less in the future, it may result in declines in aggregate long-term care expenditures.
- Nursing home and home care prices, which affect not only expenditures but also utilization. Whether prices will continue to increase faster than the consumer price index (CPI) as they have in recent years will have a large effect on the ability of individuals to pay privately for long-term care.

This section discusses how these key factors and relationships were modeled and how these analyses have been incorporated into the model.

Future Retirement Income and Assets

Approximately one-half of all long-term care expenditures for the elderly are accounted for by out-of-pocket payments made by the elderly. Because of the heavy reliance on out-of-pocket payments, understanding the level and distribution of the income and assets of the elderly is extremely important to understanding the ability of the elderly to pay for long-term care and the degree to which they must rely on public programs.

Retirement Income—In recent years the average income of the elderly has increased, and poverty rates for the elderly have declined. Much of these increases in income have stemmed from higher social security payments and the expanded role of employer pensions. In the future, the level of retirement income will depend on a number of key factors, including preretirement earnings histories of workers, the age of retirement, and the level of pension coverage.

The model simulates benefits from social security, private and public employee retirement plans, IRAs, earnings, asset income, and Supplemental Security Income (SSI) program benefits. Pension and social security benefits are simulated based on the simulated work history of an individual. Each time a worker is simulated to enter a pension-covered job, he or she is assigned to an actual pension plan sponsor selected from a representative sample of private and public retirement plan sponsors. If the individual becomes eligible for a pension benefit, the model then calculates the individual's benefit using the plan's actual benefit provisions.

The individual labor supply probabilities in the model are linked to aggregate estimates of employment levels and industry composition. The aggregate levels are based on Bureau of Labor Statistics forecasts of labor force participation rates and the distribution of workers by industry of employment.[3, 4] Aggregate unemployment rates, inflation, and real wage growth, which also influence retirement income, are based on the Social Security Actuary's II–B assumptions from the 1989 Social Security Trustees' Report. These reflect long-run real wage growth of approximately 1.3 percent per year. Labor supply in the model is described in detail elsewhere.[5]

The model's estimate of labor supply reflects the assumption that, over time, a higher proportion of workers will be employed in the services industries and a lower proportion in the manufacturing industry. This assumption has important implications for both wages and pension coverage.

Pension coverage rates in the model are assumed to remain constant on an industry-specific basis in the future. The overall pension coverage rate drops, however, because of the increasing proportion of jobs in the service industry. This is consistent with recent data from the 1983 and 1988 Special Pension Supplements to the CPS.

Assets in Retirement—For most individuals, assets are an important factor in financing long-term care expenditures. Not only are assets used to pay for long-term care, but Medicaid coverage is also conditioned upon the level of assets. The model simulates, in five steps, the level of assets and the income from these assets for persons age 65 and over. First, in 1979, each family unit with a member age 65 and over is assigned a level of assets. This level of assets is based on a distribution of assets from an analysis of the 1984 SIPP Wave 4, which was conducted by the Bureau of the Census.

The model assigns family units the level of assets of similar families from the 1984 SIPP on the basis of age, marital status, pension-receipt status, and income status. Actual individual data records from the 1984 SIPP, adjusted for inflation, are assigned to individuals simulated in the model. This allows a distribution of assets, rather than just an average amount for different demographic subgroups. The model imputes the distribution asset levels for two types of assets: home equity and all other financed assets.

In a second step, the model uses a similar procedure to assign a level and distribution of assets to families who reach the age of 65 after 1979. These probabilities are based upon the distribution and level of assets of persons who were age 63 to 67 in 1984 in SIPP. Before 1984, assets are reduced by a factor equal to the actual rate of change in the CPI over the time period. The level of assets from 1984 to the present is increased by the actual rate of change in the CPI, and in the future by the projected rate of change in the CPI assumed under the Alternative II–B assumptions. This means that, over time, the real level of assets at age 65 is assumed to remain a constant percentage of income, after controlling for marital status, income, and pension receipt status.

In a third step, the assets of elderly families are adjusted over time to reflect saving/dissaving patterns during retirement. Assumptions concerning changes in the real value of net financial assets (that is, nonhousing) are more difficult to specify because of the lack of good empirical data on dissavings in retirement. Longitudinal data from SIPP for 1984 and 1985 were used to study the saving/dissaving patterns of the elderly by selected demographic and economic characteristics. Based on these preliminary analyses, the model allows some elderly families to save, some to dissave, and others to maintain a constant real level of financial assets.

In a fourth step, the model calculates an assumed level of income from nonhousing assets for family units with a person age 65 and over. In the long run, the rate of return is assumed to be 2 percentage points above the CPI. This assumption is derived from the long-run average interest rate assumed in the Alternative II–B projections of the Social Security Administration. The long-run interest rate is 6 percent. Therefore, with an assumed 4 percent annual increase in prices, the real rate of return on financial assets in the model is 2 percent.

Finally, to reflect real increases in real estate values, the model assumes that the value of net housing assets increases 1.6 percentage points faster than the CPI. The rate of return on housing assets is expected to be lower than that on financial assets as a result of slowing growth in housing demand.

Disability—Modeling disability level and the characteristics of the disabled population is important because almost all users of long-term care are disabled. In the model, disability status for the elderly is simulated in several steps. In the first year that an individual turns 65, he or she may be assigned a disability level.[6] At the start of each subsequent simulation year, the model simulates the disability status of every individual. Various events occur during the year that affect the number of disabled elderly persons in the population, such as:

- Some persons become disabled.
- Some disabled persons have increased disability.

- Some disabled persons die.
- Some disabled persons have decreased disability or recover from their disability.
- Some disabled persons age 64 turn age 65.

In the model simulations, disabled individuals age 65 and over are defined as those who are unable to conduct at least one instrumental activity of daily living (IADL) (that is, doing heavy work, doing light work, preparing meals, shopping for groceries or other personal items, getting around inside, walking outside, managing money, or using the telephone) or are unable to conduct at least any one of five activities of daily living (ADLs) (that is, eating, bathing, dressing, "toileting," or getting in and out of bed).[7] In the model, an individual may be assigned one of four disability levels: (1) a deficiency in one or more instrumental activities of daily living (IADL only), (2) a deficiency in one activity of daily living (one ADL), (3) a deficiency in two or more activities of daily living (two or more ADLs), or (4) no disability.

The model simulates intrayear changes in disability status for persons who are admitted to or discharged from a nursing home (based on data from the 1985 NNHS) or who start to use noninstitutional services (based on data from the 1982–84 NLTCS). For all other persons in the model, changes in disability status are simulated at the start of each simulation year using an annualized disability transition matrix by age and marital status based on data from the 1982–84 NLTCS. The model takes these changes in disability status into account (that is, adjustments are made for remissions from disability and death) and simulates disability for additional persons, if necessary, to match the disability prevalence assumptions.

The model assumes that disability rates based on age/sex/marital status remain constant over time. Because mortality rates are projected to decline in the future, individuals are simulated to spend more years in disability. This has a large effect on the model results.

Long-Term Care Utilization—Another important component of the model is the simulation of nursing home use, including determination of entry and length of stay, and formal home care use.

Nursing Home Utilization—During each year some individuals are simulated to enter a nursing home. In these cases, the model simulates the length of stay and whether the individual will be discharged alive or dead. The model also simulates the individual's disability level while in the nursing home and at discharge, if discharged alive.

Nursing Home Entry—A substantial amount of research has been conducted on the characteristics of nursing home users and the probability of admission for individuals. With some exceptions, retrospective and prospective research designs have produced similar results.[8] While a number of risk factors have been identified, the studies have generally been unable to clearly separate those individuals who will enter nursing homes from those who will not.[9] The variables examined by these studies can be grouped into three broad categories: sociodemographic characteristics, health status, and social supports.

Data from the 1982–84 NLTCS were used to estimate regression equations for the probability of admission to a nursing home. Logistic models of the two-year probabilities of nursing home entry were separately estimated for disabled and nondisabled persons. The primary reason for separate models for the disabled and nondisabled was the limited data available in the NLTCS for the nondisabled. Consequently, the variables used in the model to estimate nursing home entry include:

- For the nondisabled—age, sex, marital status, and any prior nursing home stays,
- For the disabled—age, marital status, any prior nursing home stays, and disability level.

Having estimated the two-year probabilities of entry, these probabilities were then annualized and their predictive accuracy was compared against a synthetic annual admission cohort estimated from the 1985 NNHS Discharge File. The annualized probabilities were found to understate admissions for persons over age 85 compared with the 1985 NNHS. Therefore, the NLTCS admission probabilities were adjusted to reflect totals from the NNHS by estimating a regression equation by age group and prior nursing home stay, and using the coefficients as the adjustment factors.

The probabilities in the model explicitly assume that the *rates* of nursing home entry for disabled and nondisabled persons will remain constant over time on an age/sex/marital status basis. Constant rates imply, among other things, that the nursing home bed supply will increase to accommodate admissions from an increasingly large elderly population.

Nursing Home Length of Stay—The 1985 NNHS Discharge File was used to estimate the nursing home length of stay. The 1985 NNHS contains data on each nursing home stay for each individual in the survey. To obtain the length of stay for complete episodes, lengths of stay were aggregated for persons who were discharged from nursing homes and who reentered a nursing home within 30 days of discharge. To examine how individuals pay for nursing home stays accurately, it is important to capture complete episodes of care.

The model assumes that nursing home lengths of stay, on an age and marital status basis, will remain constant over time.

Home Care Utilization—The model simulates both the use of formal home care services and the length of use. Home care utilization for purposes of this discussion includes any home health, homemaker, personal care, or meal preparation services for which the caregiver is reimbursed by the elderly recipient, Medicare, Medicaid, or funds from other public payers. These funds come from the Older Americans Act, state and local programs, social services, block grant monies, Veterans' Administration programs, and charity among other sources. Data from the 1982–84 NLTCS were used to estimate the use of home care. NLTCS data on the characteristics of persons in 1982 were used to predict utilization of home care services and length of use in 1984. Over time, the likelihood of using home care services and length of use are assumed to remain constant on an age/sex/disability basis for persons in the community.

Long-Term Care Prices

Long-term care prices, such as those for nursing home and home care, have a profound impact on the sources of financing for long-term care because many individuals deplete their assets and "spend down" onto Medicaid after long stays in a nursing home.

In the model, national averages are used for long-term care prices. For nursing home prices, daily rates are used for Medicare, Medicaid, and private pay. The Medicare rate is based on HCFA estimates of the average Medicare SNF per diem rate. The Medicaid daily rate is based on average SNF and ICF Medicaid payment rates in 1985 from the NNHS Facility File, weighted by the number of residents receiving Medicaid SNF or ICF payment in the 1985 NNHS. The private pay rate is based on average SNF and ICF private charges in 1985 from the NNHS Facility File, weighted by the total number of beds in a facility certified for SNF or ICF use. The 1985 Medicaid and private pay rates were adjusted to 1988 based on HCFA estimates of changes in nursing home prices over the period. Table E-1 shows the rates used in the model in 1990.

The annual long-term care inflation rate for nursing home and home care prices in the model is assumed to be 5.5 percent. This annual rate is equal to the projected rate of growth in compensation as specified in the 1989 Social Security Trustees' Report (4.0 percent increase in the CPI, 1.3 percent increase in real wages, and 0.2 percent increase in fringe benefits). This is equivalent to 1.5 percent annual real growth in long-term care prices over the long run. The rationale for using the growth in compensation is that it reflects the high proportion (approximately 70 percent) of labor costs in total long-term care service costs. It assumes that nursing home and home care wages and other benefits will increase at a rate comparable with that of the rest of the economy. It also assumes there will not be any change in the proportion of labor costs relative to other costs in nursing homes or home care.

Table E-1 Prices Assumed in the Model for Services, by Source of Financing, 1990

Source of Financing	Nursing Home Daily Rate	Home Care Price Per Visit
Medicaid	$61.55	$60.30
Medicare	141.90	63.30
Other public payer	N/A	31.20
Out-of-pocket	84.50	15.50

N/A = not applicable.

MODELING THE COMMISSION RECOMMENDATIONS

The Commission has proposed the establishment of a comprehensive public program to meet the needs of the long-term care population. The plan consists of three components, which together address the needs of institutionalized and community-based, severely disabled Americans. The first part of the proposal would provide social insurance for home and community-based care for severely disabled individuals. Under a second part of the proposal, persons who qualify for institutional care would be entitled to social insurance covering the first three months of their nursing home stay. Finally, for persons remaining in nursing homes beyond the three-month period covered under the social insurance, the plan would provide significantly higher income and asset protection than is available under the current Medicaid program.

The Brookings/ICF Long-Term Care Financing Model was used to simulate the cost of the proposed program and the program's impact on elderly Americans now and in the future. Estimates were made in 1989 dollars for the 1991 to 1995 period and for the 2016 to 2020 period. This section discusses in detail the various provisions of the proposal and their implementation within the framework of the model.[10]

Social Insurance for Home and Community-Based Care

The proposal would provide public coverage of home and community-based care for severely disabled individuals of all ages. Specifically, this program would provide "hands-on or supervisory" assistance to persons having three or more ADL limitations or having severe cognitive impairment. Under the proposal, case managers would determine the number of hours of care and mix of services received by beneficiaries, subject to a budget. The budget reflects per capita amounts that vary by disability level. The types of benefits provided under this portion of the proposal would include skilled nursing services, therapy services, personal care services, homemaker chore services, grocery shopping and transportation, medication management, adult day care, respite care, and training and counseling services for caregivers. The plan would require beneficiary copayment of 20 percent of the lesser of costs of care or the national average cost of care. For individuals with incomes below 200 percent of the federal poverty level, however, the federal government would subsidize copayment requirements (see Table E–2).

This proposal was implemented within the structure of the Brookings/ICF Long-Term Care Financing Model in the following way.

First, the number of users was modeled. Elderly persons with three or more ADL limitations or a similar level of cognitive impairment were assumed to be eligible for the benefit. The model does not identify these groups directly. It does, however, have data on persons with two or more ADL deficiencies. To estimate the number of persons eligible for the Commission proposal, the NLTCS was used to estimate the number of persons who would meet the proposal's eligibility criteria as a percentage of persons in the NLTCS with two or more ADL deficiencies. (To meet these criteria an individual must have three or more ADL limitations, severe cognitive impairment, or disruptive or dangerous behavior.) This percentage was then applied to the model's estimates of the number of persons with two or more ADL deficiencies.

Table E–2 Percentage of Copayment Subsidized Under Commission Plan, by Income Level

Income Level	Percentage of Copayment Subsidized	Effective Copayment Rate
Less than poverty level	100%	0%
100–149% of poverty level	75	5
150–199% of poverty level	50	10
200% or more of poverty level	0	20

All persons who met these eligibility criteria *and* who currently receive formal home care services were assumed to receive benefits under the program. This may be an overestimate of the number of people eligible for the Commission's proposal because it includes those who need special equipment, while the Commission's proposal includes only persons who need hands-on or supervisory assistance. It was assumed that 80 percent of eligible persons would participate in the program (see the section on induced demand).

The number of visits each user would receive was then modeled. The program establishes a budget within which the case manager allocates services. Estimates assume a maximum of 25 hours per week. If one assumes that each visit is four hours long (including travel time), then program beneficiaries would receive up to 27 visits per month. Current users of formal services were assumed to receive the same number of visits they do now, subject to the 27 visit per month maximum. New users of program services were assumed to have the same distribution of visits as current users of formal care. On the one hand, this may underestimate the increase in services because it assumes current users do not increase their use of services. On the other hand, it may overestimate the use of program services because it assumes that all new users receive services at the same intensity that current users do.

Program payment levels were then modeled. The program rates for home and community-based care used in the model are based on estimates of 1990 Medicaid costs per visit ($60.30 per visit), with an additional 20 percent for case management. An additional assessment cost of $100 per participant in 1989 dollars was assumed.

Beneficiary cost sharing was then modeled. No deductible applies to the benefit; however, a copayment of 20 percent of the cost of care is required. Individuals with income below 200 percent of the poverty level were assumed to receive subsidies toward their required copayment as indicated in Table E–2.

Finally, all persons qualifying for current programs who do not meet the eligibility criteria for the home and community-care benefit were assumed to continue to be served by these programs. This includes persons eligible for the Medicare home health benefit.

Three-Month Front-End Coverage of Nursing Home Stays

Under the proposal, all nursing home users would receive coverage for the first three months of their nursing home stay. Covered services include skilled nursing care and custodial care.

In modeling this part of the proposal, it was assumed that all entrants to nursing homes would receive the benefit (that is, current residents would not receive the benefit). A lifetime benefit limit of three episodes was also assumed. The required copayment of 20 percent of the cost of care was assumed to be subsidized at the rates in Table E–2 for beneficiaries with incomes below 200 percent of the poverty level. A payment rate in 1990 of $76.95 per day (125 percent of the current national average Medicaid rate) was assumed. This is about 10 percent less than the current private pay rate for nursing homes. Rates close to but less than the average private pay rate reflect the proposal's intent to ensure access to care while using the government's bargaining power to control costs.

Long Nursing Home Stays

The nursing home program provides income and asset protection for nursing home users of all ages who are judged eligible for nursing home care by a federally certified assessment agency. Covered services include skilled nursing care and custodial care. This coverage is effective through the entire length of a nursing home stay.

The proposal would protect $30,000 in nonhousing assets for single individuals and $60,000 for couples. Individuals having financial assets in excess of these amounts must contribute unprotected assets toward the cost of their care. Under the program, income projections include a housing allowance of 30 percent of income for at least the first year of a nursing home stay. For married beneficiaries, the housing allowance is extended up to one year after a spouse is no longer in the community. In addition, the plan provides a monthly personal needs allowance of $100 for all beneficiaries. Community-based spouses of beneficiaries may retain any income up to the 200 percent of the federal poverty level for elderly couples. Any remaining income is contributed toward the cost of nursing home care received by the beneficiary. All of these provisions were modeled directly in the model. It was assumed that current residents would be eligible for the benefit.

Induced Demand

The proposed program is likely to increase costs for three reasons. First, many persons who currently are not eligible for long-term care services will be covered by the proposed programs. Second, those currently eligible for long-term care benefits will bear a smaller share of their costs directly, depending on the nature of the program. Third, with a reduction in cost to the individual, additional persons will seek services, and those currently receiving services may seek more services. The third effect is referred to as induced demand.

Concern about the impact of proposed financing changes on service use is understandable, particularly in light of the way services are used today. Under current methods of financing, a high percentage of long-term care services is provided voluntarily by relatives. In addition, a large number of disabled elderly and nonelderly persons who do not receive services could be medically eligible if services were covered.

Unlike acute care, little research has been conducted on the effect of induced demand on the use of long-term care services. The primary reason may be that the effect is hard to measure. Because of the potential impact of induced demand on the use and costs of long-term care services, however, it must be considered as a component in the financing of these private and public proposals.

All the estimates of induced demand for long-term care services are derived from analyses of the demand for nursing home care. Studies use different methodologies, but the range and size of the price elasticities are narrow compared with those in the literature on the demand for acute care services.[11, 12] In general, the studies found highly elastic responses to price that range from a 10 percent decrease in price leading to an increase in demand from 7 percent to 23 percent. Regardless of which estimate is correct, even the lowest implies that private consumers of nursing home care are very responsive to price changes—that is, lowering prices will result in relatively large increases in the use of services.

Although the evidence from the demand for nursing home care literature suggests that use would increase a great deal, one should probably not use the literature estimates directly for five reasons. First, data from some studies are old and may not reflect current behavior, and the ability to generalize from others is limited.[13]

Second, these studies are cross-sectional; therefore, the range of price elasticity estimates may reflect true differences in the populations sampled or simply differences in specification.

Third, according to recent surveys, the overwhelming majority of disabled elderly want to stay out of nursing homes.

A fourth issue is that price elasticities become less relevant when the nursing home bed supply is constrained by government regulation.

Finally, the program recommended by the Commission contains both home care and nursing home care provisions. Assuming that home care and nursing home care are to some extent substitutes, neither the nursing home induced demand effect nor the home care induced demand effect may be as large as the studies discussed might suggest.

Based on the estimate of the effective reduction in the price of care facing consumers, use of home care services is assumed to double under the Commission's proposal, and the probability of use is adjusted accordingly. Currently about 40 percent of those who would be eligible for care under the proposal use paid home care services at a point in time. In modeling the proposal it was assumed that this number will increase to approximately 80 percent. This assumes all current users of formal care, and approximately two-thirds of eligible nonusers, would participate in the program.

Similarly, the decrease in the out-of-pocket cost of institutional care will increase utilization of nursing home services. In modeling the proposal it was assumed that the reduction in the price of nursing home care would increase utilization 20 percent.

Estimating the Cost of Long-Term Care for the Nonelderly

Data on the long-term care needs of the nonelderly are limited to estimates of the size of this population.[14] Precise estimates of severity of the disabilities, as well as current long-term care use or coverage from existing public programs, are not available. Therefore, the estimates of the net federal costs of providing long-term care services to the nonelderly were based on simple proportions based on the net per capita costs of the elderly applied to the nonelderly. Specifically, the *net* federal costs of providing home health care to the nonelderly were based on the per capita costs of the eligible elderly applied to the total number of nonelderly estimated to have any limitation in activities of daily living. Costs for the nonelderly population were estimated as 75 percent of this cost. Some of these individuals would not qualify as severely disabled, and others were expected to be receiving federal assistance through Medicaid, Medicare, or another public program.

To estimate the net federal cost of the nursing home portions, the net federal cost of the elderly population was simply increased by the current proportion of nonelderly nursing home residents.

Notes to Appendix E

1. Prepared by David L. Kennell, Lisa Alecxih, and Dhiren Patel of Lewin/ICF and Joshua M. Wiener of The Brookings Institution.

2. In the model, a Monte Carlo simulation methodology is used to simulate changes in an individual's status by drawing a random number between zero and one and comparing it to a fixed probability of that event occurring for an individual with a given set of sociodemographic characteristics. For example, the annual probability of death for an 85 year old noninstitutionalized female is assumed to be 0.03 (that is, three out of every 100 women age 85 who are not in a nursing home are expected to die each year). If the random number drawn by the model is less than or equal to 0.03 for this 85-year-old woman, then the individual is assumed to die in that year. If the number drawn lies between 0.03 and 1.00, then the individual is assumed to continue to live during that year.

3. Harold Fullerton Jr., "Labor Force Projections 1986–2000," *Bureau of Labor Statistics Monthly Labor Review* 110 (9) (September 1987): 19–29.

4. George Silversti and John Lukasiewicz, "A Look at Occupational Employment Trends to the Year 2000," *Bureau of Labor Statistics' Monthly Labor Review* 110 (9) (September 1987): 46–63.

5. David L. Kennell and John Sheils, *Documentation of the Pension and Retirement Income Simulation Model (PRISM)* (Washington, D.C.: ICF Incorporated, September 1986).

6. This occurs in every year except 1979, when the model simulation starts. In this year, a disability status is simulated for all persons age 65 and over, based on the prevalence rates estimated from the 1982–84 NLTCS. Sixty percent of individuals receiving Disability Insurance program benefits at age 62 are simulated to continue to be disabled when they reach age 65.

7. In the 1982–1984 NLTCS, disability was defined as the inability to conduct any of the activities of daily living or instrumental activities of daily living due to a health condition which had or would endure for 90 days or more. The measure used in the model is based upon the control card in the NLTCS and therefore includes persons who require active human assistance, standby assistance, or assistance from special equipment.

8. Raymond J. Hanley, Lisa Maria B. Alecxih, Joshua M. Wiener, and David L. Kennell, "Prediction Elderly Nursing Homes Admissions: Results From the 1982–84 National Long-Term Care Survey," *Research on Aging* 12 (2) (June 1990): 199–228; Korbin Liu and Kenneth Manton, "The Characteristics and Utilization Patterns of an Admission Cohort of Nursing Home Patients," *The Gerontologist* 23 (1) (February 1983): 92–98; William Weissert and William Scanlon, "Determinants of Institutionalization of the Aged," *Project to Analyze Existing Long-Term Care Data, Volume III* (Washington, D.C.: The Urban Institute, 1983): 1–19; Leticia Vincente, James A. Wiley, and R. Allen Carrington, "The Risk of Institutionalization Before Death," *The Gerontologist* 19 (4) (August 1979): 361–367; A.S. Kraus, R.A. Spasoff, E.J. Beattle, D.E.W. Holden, J.S. Lawson, M. Rodenburg, and G.M. Woodcock, "Elderly Applicants to Long-Term Care Institutions," *Journal of American Geriatric Society* 14 (3) (Fall 1976): 117–25; Jay N. Greenberg and Anna Ginn, "A Multivariate Analysis of the Predictors of Long-Term Care Placement," *Home Health Care Services Quarterly* 1 (1) (Spring 1979): 75–99; Erdman Palmore, "Total Chance of Institutionalization Among the Aged," *The Gerontologist* 16 (6) (December 1976): 504–7.

9. Marc A. Cohen, Eileen J. Tell, and Stanley J. Wallack, "The Lifetime Risks and Costs of Nursing Home Use Among the Elderly," *Medical Care* 24 (12) (December 1986): 1162; Lawrence G. Branch and Alan M. Jette, "A Prospective Study of the Long-Term Care Institutionalization Among the Aged," *American Journal of Public Health* 72 (12) (December 1982): 1374.

10. We would like to acknowledge the direction and support of the assistant secretary for planning and evaluation, HHS, in the modeling work.

11. Barry Chiswick, "The Demand for Nursing Home Care: An Analysis of the Substitution Between Institutional and Non-Institutional Care," *Journal of Human Resources* 11 (3) (Summer 1976): 295–316; Alvin Headen, "Insurance-Induced Demand and the Hazard of Nursing Home Entry," North Carolina State University and Duke University Center of Demographic Studies, Faculty Working Paper No. 152, 1989; John Nyman, "The Private Demand for Nursing

Home," *Journal of Health Economics* 8 (2) (June 1989): 209–31; John Nyman, "Analysis of Nursing Home Use and Bed Supply: Wisconsin, 1983," *Health Services Research* 24 (4) (October 1989): 511–37; and, William Scanlon, "A Theory of the Nursing Home Market," *Inquiry* 17 (1) (Spring 1980): 25–41.

12. For a more detailed discussion of the literature on induced demand for long-term care see, Theresa Fama and David L. Kennell, "Should We Worry About Induced Demand for Long-Term Care Services?" *Generations* XIV (2) (Spring 1990): 37–41.

13. Chiswick, "Demand for Nursing Home Care"; Nyman, "Nursing Home Use: Wisconsin"; and, Scanlon, "Nursing Home Market."

14. Estimates prepared by Pepper Commission staff.

Appendix F

Revenue Options

This appendix illustrates in several ways the many combinations of revenue sources possible to finance the Commission recommendations.[1] First, Table F–1 lists potential revenue sources, the amounts of revenues that could be raised from each source, once fully phased in, and how well each source meets the criteria established by the Commission. These criteria specify that any revenue package must be progressive, must require contributions from all citizens, and must grow at a rate sufficient to support growth in the recommended benefits.

Since a financing package may be composed of taxes from several sources, Table F–2 offers six options to illustrate the range of effects on taxpayers. Each option is large enough to support the Commission recommendations once fully phased in; in practice, its components could also be phased in, since all of the revenues will not be needed at once. Each option also draws upon at least one major revenue source, such as the income tax or the payroll tax, with other smaller revenue sources designed to help meet the criteria for an acceptable overall package. Two of the options assume that part of the revenues could be obtained from a realignment of current budget priorities—drawing upon reductions in other federal spending. These optional packages illustrate that it is possible to raise the necessary revenue from many different combinations of sources.

To help clarify the impact of these various options, several pieces of information are presented. Figures F–1 through F–6 present tables and graphs to illustrate how each would affect taxpayers in different income groups. The distributional tables and the estimates of total revenue were provided to the Commission by Price Waterhouse. The goal was to conform as closely as possible to specifications for such estimates by the Joint Committee on Internal Revenue Taxation. Some of the revenue sources, which cannot readily be distributed across taxpayers, are not included in the tables.

Finally, Exhibit 1 shows the increase in tax liabilities from the options that would arise for eight prototypical households. These are not necessarily representative households, but were chosen to highlight impacts on a broad range of different types of taxpayers. The descriptions of the households note the assumptions necessary to estimate tax liabilities from the various sources.

Together, these materials underscore that there are many possible combinations of revenue sources that could achieve the goals of the Commission. The Commission does not endorse any particular option or the particular elements of any option shown here. Other revenue sources or combinations that are not included might reasonably be considered. The objective in presenting options is simply to illustrate alternative approaches to raising the revenues needed to put the Commission recommendations into effect.

Table F-1 Description and Impact of Revenue Sources

Tax Proposal	1993 Revenues (billions, 1990)	Growth Potential [a]	Degree of Progressivity	Population Affected
Personal Income Tax Rates				
Increase the marginal tax rates from the present rates of 15 percent and 28 percent to 16 percent and 30 percent, respectively. This option implicitly increases the 33 percent "bubble" to 35 percent.	$33.5	Moderate	Moderate	Comprehensive
Add a 5 percent surtax to everyone's income tax liability.	24.3	Moderate	Moderate	Comprehensive
Add a formal 33 percent tax bracket by keeping the current "bubble" and extending the 33 percent bracket to all taxpayers with taxable incomes above the "bubble."	7.6	High	High	Comprehensive [b]
Add a formal 33 percent tax bracket as above and a 5 percent surtax to everyone's liability.	33.0 [c]	High	High	Comprehensive
Increase the 28 percent tax rate to 30 percent. Implicitly increases the 33 percent bubble to 35 percent.	19.1	High	High	Comprehensive [b]
Repeal the indexation of the income tax that each year raises the levels of taxable income at which tax rates change.	24.7	High	Low	Comprehensive
Delay indexing of the income tax until 1992.	9.5	High	Low	Comprehensive
Personal Income Tax Base				
Subject the part of employer paid health insurance premiums over $250 per month (family coverage) to the income tax.	5.5	High	High	Workers
Subject all employer paid life insurance premiums to the income tax. Currently, premiums paid by employers on the first $50,000 of group term plans are excluded from taxable income.	2.0	Low	High	Workers
Allow only one-half of all business meals and entertainment to be deducted from the income tax. Currently 80 percent may be deducted.	3.2	Moderate	High	Workers
Limit interest deductions for second homes by requiring that they qualify under the $100,000 limit on home equity loans.	0.3	Low	High	Comprehensive [b]
Limit the deductibility of interest on a home mortgage to no more than $20,000 per joint return and $12,000 per single return.	1.6	High	High	Comprehensive [b]

Table F-1 Description and Impact of Revenue Sources—Continued

Tax Proposal	1993 Revenues (billions, 1990)	Growth Potential [a]	Degree of Progressivity	Population Affected
Limit the amount of state and local taxes that can be deducted to amounts in excess of 1 percent of adjusted gross income.	4.6	Moderate	Low	Comprehensive
Subject 85 percent of Social Security benefits to the income tax for those whose incomes exceed the current threshold of $25,000 for single returns and $32,000 for joint returns. Currently, only 50 percent is subject to tax.	3.9	High	High	Aged/disabled
Subject 85 percent of Social Security benefits to the income tax for those whose incomes exceed lower thresholds of $18,000 for joint returns and $12,000 for single returns.	10.0 [3]	High	High	Aged/disabled
Subject 60 percent of Social Security benefits to the income tax for all beneficiaries.	10.1	Moderate	Moderate	Aged/disabled
Corporate Income Tax				
Add a 5 percent surtax to all corporations' income tax liabilities.	5.3	Moderate	High	N/A
Increase the top corporate rate to 35 percent. Currently the rate is 34 percent.	2.4	Moderate	High	N/A
Raise the alternative minimum tax rate that corporations must pay to 25 percent from its current rate of 20 percent.	2.2	Low	High	N/A
Excise Taxes				
Raise cigarette taxes from 16 to 32 cents per pack.	2.5	Low [d]	Low	Users
Increase taxes on distilled spirits, beer and wine to $0.25 per ounce of ethyl alcohol. Currently, distilled spirits are taxed at a rate of $0.20 per ounce and beer and wine are taxed at about $0.05 and $0.01 per ounce, respectively.	6.5	Low [d]	Low	Users
Increase the motor fuel tax by 12 cents per gallon. Currently, the federal tax on gasoline is set at 9.1 cents per gallon and diesel fuel at 15.1 cents per gallon.	10.0	Low [d]	Low	Users
Impose a tax of $5 per barrel on all domestic and imported crude oil.	18.1	Low [d]	Low	Comprehensive
Impose a 1 percent tax on all revenues generated by hospitals.	2.0 [e]	High	High	Comprehensive
Impose a 1 percent excise tax on health insurance claims payments.	2.0 [e]	High	High.	Comprehensive

Table F-1 Description and Impact of Revenue Sources—Continued

Tax Proposal	1993 Revenues (billions, 1990)	Growth Potential[a]	Degree of Progressivity	Population Affected
Payroll Tax				
Raise the combined tax on employers and employees by 1½ percent and expand the earned income tax credit to offset the increased payroll tax on low income workers.	32.0[c]	Moderate	Moderate	Workers
Eliminate the maximum amount of wages subject to the Medicare payroll tax, thus applying the tax to all wages. The 1990 taxable maximum is $51,300.	9.2	Moderate	High	Workers
Eliminate the maximum on the amount of wages subject to the payroll tax that funds Social Security's Old Age, Survivors and Disability Programs.	39.3[c]	Moderate	High	Workers
Expand Medicare coverage to state and local government employees who are not now covered by the program. This would require state and local workers hired before April 1, 1986, to begin paying the Medicare payroll tax.	1.4	Low	Low	State/local workers
Include the value of employer paid health insurance premiums in excess of $250 per month in the Social Security wage base.	3.1	High	High	Workers
Include the value of employer paid life insurance in the Social Security wage base.	1.1	Low	High	Workers
Estate Taxes				
Include capital gains in the last income tax return of the deceased. Currently, an inherited asset is not taxed on any gains made over the life of the deceased.	2.0	Low	—[f]	Heirs
Decrease the amount exempt from the federal estate and gift taxes by lowering the credit allowed to the equivalent of the 1982 level adjusted for inflation. This would exempt the first $300,000 from taxation as opposed to the current exemption of $600,000.	1.0	Low	—[f]	Heirs
Value-added Tax				
Impose a 5 percent value-added tax on a broadly defined consumption base.	118.8	Moderate	Low	Comprehensive

Table F-1 Description and Impact of Revenue Sources—Continued

Tax Proposal	1993 Revenues (billions, 1990)	Growth Potential [a]	Degree of Progressivity	Population Affected
Impose a 5 percent value-added tax on consumption but exclude from the base expenditures on food, housing, and medical care.	69.2	Moderate	Low	Comprehensive
Medicare Premium				
Impose an additional $5 per month premium on all Medicare enrollees with incomes above 200 percent of poverty and automatically increase the premium each year by the rate of increase in the consumer price index.	1.2 [b]	Moderate	Low	Aged/disabled

[a] Growth potential is classified as follows: "low" means less than 5 percent per year; "moderate" means 5 percent to 10 percent per year; "high" means more than 10 percent per year.

[b] The designation as "comprehensive" in this instance does not mean that everyone pays; rather, no single group is excluded by any characteristic other than income.

[c] Estimates extrapolated from other published sources.

[d] Growth potential could be increased by making taxes a percent of revenues (an ad valorem tax) rather than flat dollar amounts.

[e] These estimates are not from the Joint Tax Committee but are rather based on simple projections of hospital and health insurance revenues.

[f] Since estate taxes are imposed on the estates of deceased persons, and remaining amounts are distributed to the decedent's heirs, and since few data are available concerning the incomes of heirs, no consensus exists among analysts about how to assess the progressivity of estate taxes.

SOURCE: Unless otherwise noted, Joint Tax Committee, February 1990. Revenue estimates reflect 1993 amounts, to allow taxes to be fully phased in, and are expressed in 1990 dollars to enhance comparability with cost figures.

Table F-2 Revenue From Six Possible Revenue Options

Provision	*1990 Revenue (Billions)*
Revenue From Option 1	
1.9 percent increase in combined FICA rate	$44.7
EITC credit @ 15.9 percent up to $993	(4.0)
Increase in cigarette tax	2.9
Increase in beer and wine tax, index	4.8
33 percent top rate	5.8
Tax capital gains at death *	5.1
Tax up to 85 percent of social security benefits	3.5
Eliminate HI taxable maximum	7.8
Total	$70.6
Revenue From Option 2	
Impose a 4 percent VAT with exemptions for food, shelter, and health expenditures	$54.3
33 percent top rate	5.8
Tax up to 85 percent of social security benefits and lower thresholds	7.3
Cap income tax preference for employer health insurance payments *	5.2
Total	$72.6
Revenue From Option 3	
33 percent top rate/7 percent surtax	$36.7
Increase in cigarette tax	2.9
Increase in beer and wine tax, index	4.8
Tax capital gains at death *	5.1
Tax up to 85 percent of social security benefits and lower thresholds	7.3
Cap income tax preference for employer health insurance payments *	5.2
Eliminate HI taxable maximum	7.8
Total	$69.8
Revenue From Option 4	
Supplemental tax of 4.5 percent on modified gross income over $32,000 ($16,000) for joint (single) returns	$75.0
Revenue From Option 5	
Eliminate taxable maximum on FICA payments	$40.6
Tax capital gains at death *	5.1
Increase in cigarette tax	2.9
Increase in beer and wine tax, index	4.8
Impose a 3 percent surtax	13.6
Reductions in other federal spending assumed *	5.0
Total	$72.0
Revenue From Option 6	
1.6 percent increase in combined FICA rate	$32.5
Increase 28 percent rate to 29 percent and replace current 33 percent/28 percent "bubble" with a 34 percent rate	12.1
Eliminate HI taxable maximum	7.8
Tax up to 85 percent of social security benefits	3.5
Tax capital gains at death *	5.1
Reductions in other federal spending assumed *	10.0
Total	$71.0

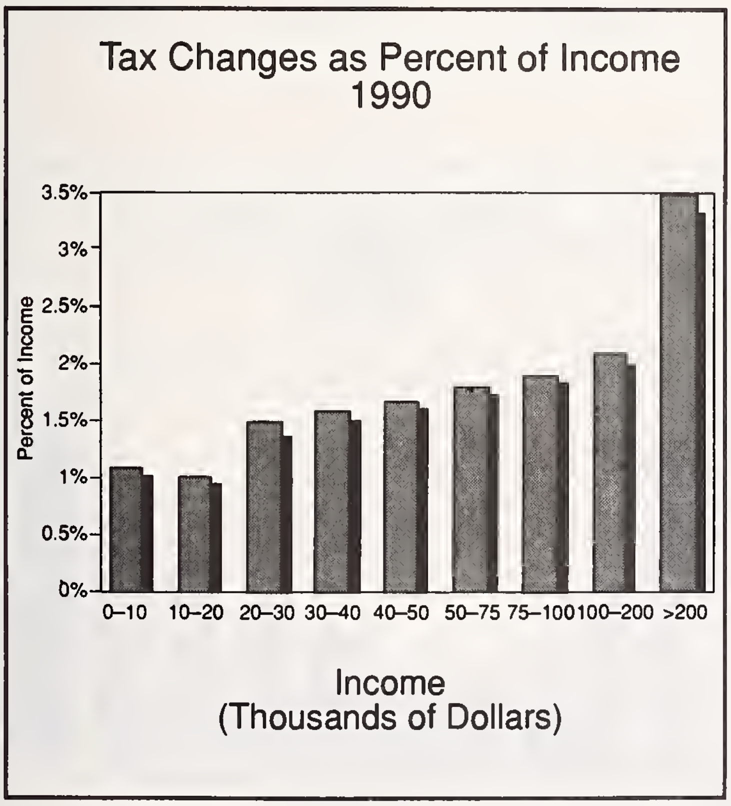
* These amounts are not distributed across income classes in the distributional analysis displayed in Figures F-1 through F-6.

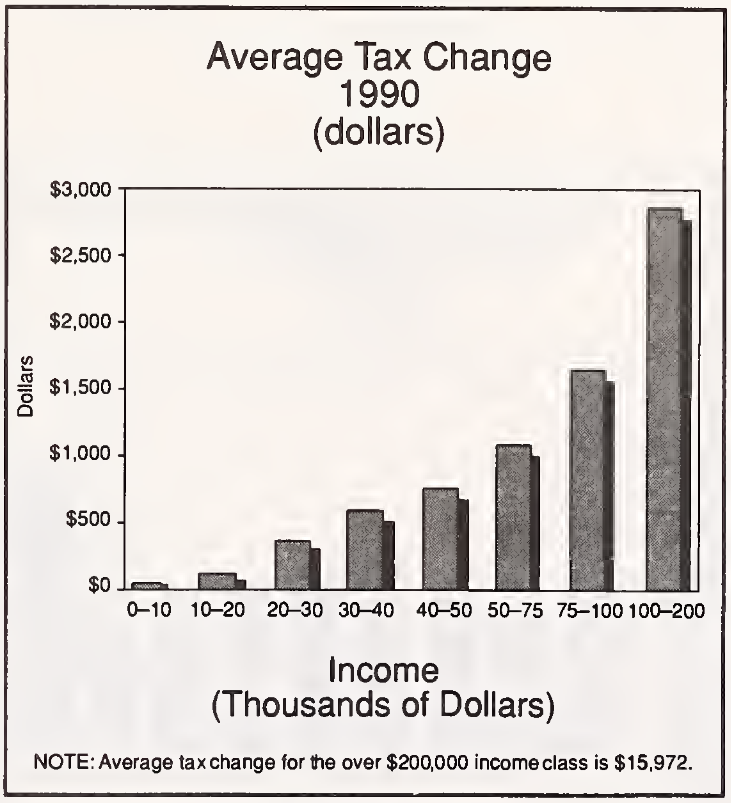
NOTE: Revenues are amounts that would be generated in 1990 if the provisions were fully in force during the entire year.

SOURCE: Price Waterhouse.

Figure F-1—Option 1: Impact on Taxpayer, by Income Class*

			Distribution of:	
Income	Returns (thousands)	Cumulative Share of Total Returns	Tax Change as a Percentage of Income	Average Tax Change (dollars)
$0–10,000	27,292	23.4%	1.1%	$55
10,000–20,000	27,938	47.3	1.0	140
20,000–30,000	18,952	63.5	1.5	362
30,000–40,000	13,382	75.0	1.6	570
40,000–50,000	9,169	82.8	1.7	743
50,000–75,000	12,086	93.2	1.8	1,071
75,000–100,000	4,242	96.8	1.9	1,632
100,000–200,000	2,881	99.3	2.1	2,755
over 200,000	827	100.0	3.5	15,972
Total	116,769		1.9%	$624


Tax Changes as Percent of Income
1990


Average Tax Change
1990
(dollars)

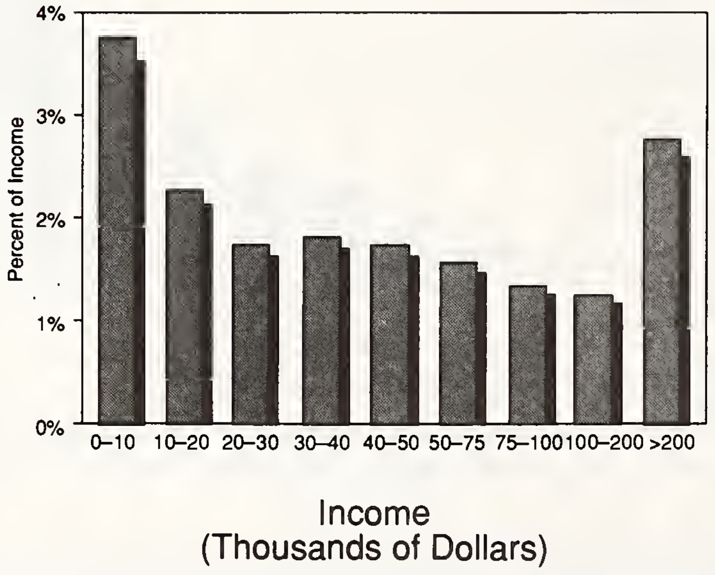
NOTE: Average tax change for the over $200,000 income class is $15,972.

*NOTES: Some $5.1 billion, or 6.9 percent of the total revenue raised, is unallocated in the distribution but is allocated to the totals.
Distribution is presented without assuming behavioral response to changes in capital gains treatment.
"Income" in these tables is calculated as adjusted gross income increased by untaxed social security and pension benefits plus IRA and KEOUGH deductions, plus AFDC and SSI benefits. This income measure is calculated using current income; some analysts argue that a better measure is income over a lifetime or "permanent" income. The distributional analysis of VAT using a permanent income classifier would produce generally less regressive results.
Both the employer and employee portions of the payroll tax are, net of income tax offsets, attributed to the employee. Some analysts would not distribute all of the employer portion of the tax in this way, producing somewhat less regressive results.
Consistent with Joint Tax Committee presentation, dependent tax filers are not included in the distributional materials. Returns with income less than zero are also excluded.
SOURCE: Price Waterhouse

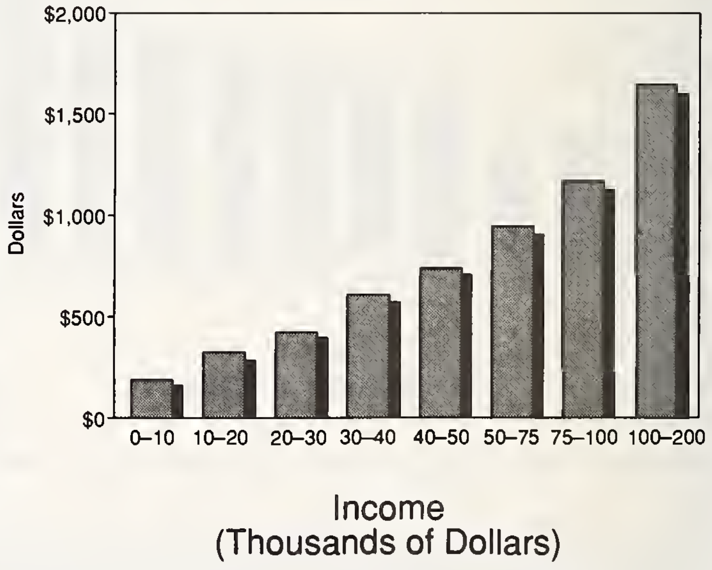
Figure F-2—Option II*

Income Class	Returns (thousands)	Cumulative Share of Total Returns	Distribution of: Tax Change as a Percentage of Income	Distribution of: Average Tax Change (dollars)
$0–10,000	27,292	23.4%	3.7%	$188
10,000–20,000	27,938	47.3	2.3	332
20,000–30,000	18,952	63.5	1.7	428
30,000–40,000	13,382	75.0	1.8	614
40,000–50,000	9,169	82.8	1.7	745
50,000–75,000	12,086	93.2	1.6	957
75,000–100,000	4,242	96.8	1.4	1,176
100,000–200,000	2,881	99.3	1.3	1,664
over 200,000	827	100.0	2.7	12,609
Total	116,769		2.0%	$638

Tax Changes as Percent of Income
1990



Average Tax Change
1990
(dollars)

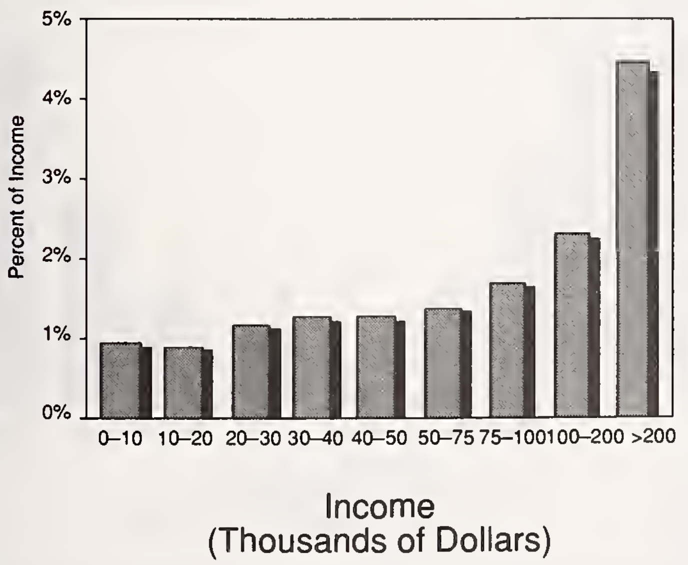


NOTE: Average tax change for the over $200,000 income class is $12,609.

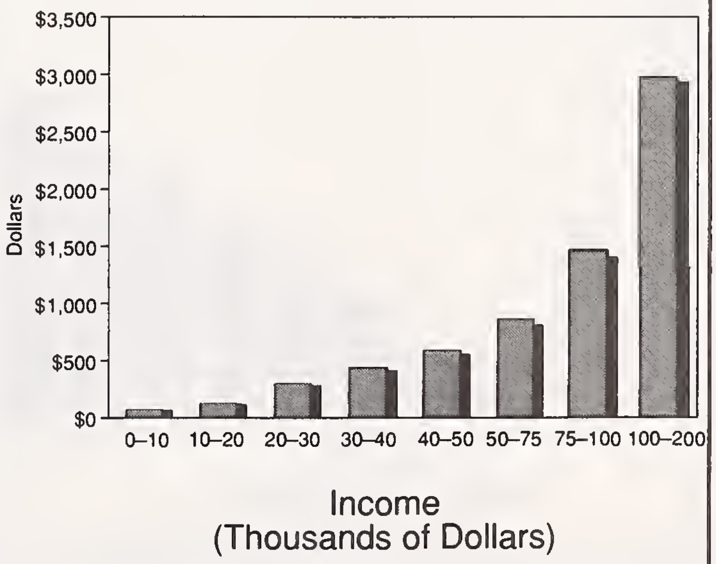
*NOTE: Some $5.2 billion, or 7.2 percent of the total revenue raised, is unallocated in the distribution but allocated in the totals. For further notes, see Figure F-1.
SOURCE: Price Waterhouse

Figure F-3—Option III*

Income Class	Returns (thousands)	Cumulative Share of Total Returns	Distribution of: Tax Change as a Percentage of Income	Distribution of: Average Tax Change (dollars)
$0–10,000	27,292	23.4%	.09%	$47
10,000–20,000	27,938	47.3	.08	111
20,000–30,000	18,952	63.5	1.1	271
30,000–40,000	13,382	75.0	1.3	461
40,000–50,000	9,169	82.8	1.3	572
50,000–75,000	12,086	93.2	1.4	848
75,000–100,000	4,242	96.8	1.7	1,487
100,000–200,000	2,881	99.3	2.3	2,992
over 200,000	827	100.0	4.4	20,378
Total	116,769		2.0%	$627



Tax Changes as Percent of Income
1990



Average Tax Change
1990
(dollars)

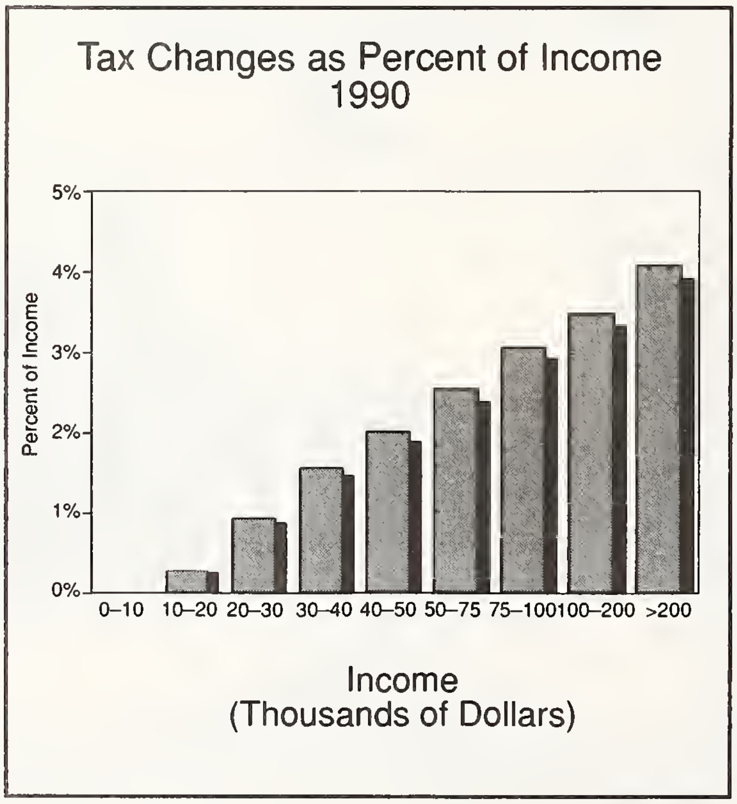
NOTE: Average tax change for the over $200,000 income class is $20,378.

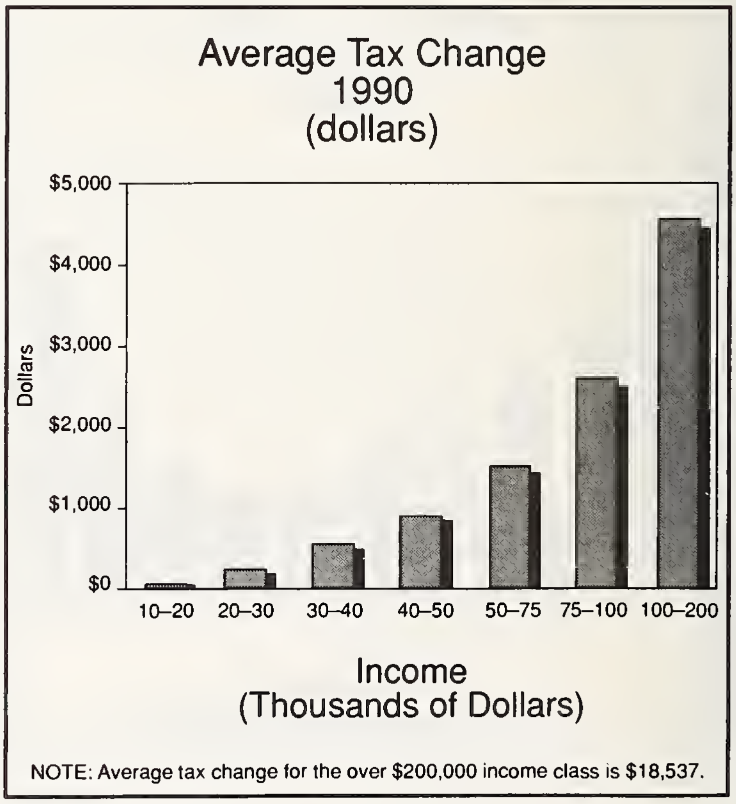
*NOTE: Some $10.3 billion, or 14.7 percent of the total revenue raised, is unallocated in the distribution but allocated in the totals. For further notes, see Figure F-1.

SOURCE: Price Waterhouse

Figure F-4—Option IV*

Income Class	Returns (thousands)	Cumulative Share of Total Returns	Distribution of: Tax Change as a Percentage of Income	Distribution of: Average Tax Change (dollars)
$0–10,000	27,292	23.4%	0.0%	$0
10,000–20,000	27,938	47.3	0.3	39
20,000–30,000	18,952	63.5	0.9	230
30,000–40,000	13,382	75.0	1.5	531
40,000–50,000	9,169	82.8	2.0	891
50,000–75,000	12,086	93.2	2.5	1,524
75,000–100,000	4,242	96.8	3.0	2,582
100,000–200,000	2,881	99.3	3.5	4,534
over 200,000	827	100.0	4.0	18,537
Total	116,769		2.1%	$672


Tax Changes as Percent of Income
1990


Average Tax Change
1990
(dollars)

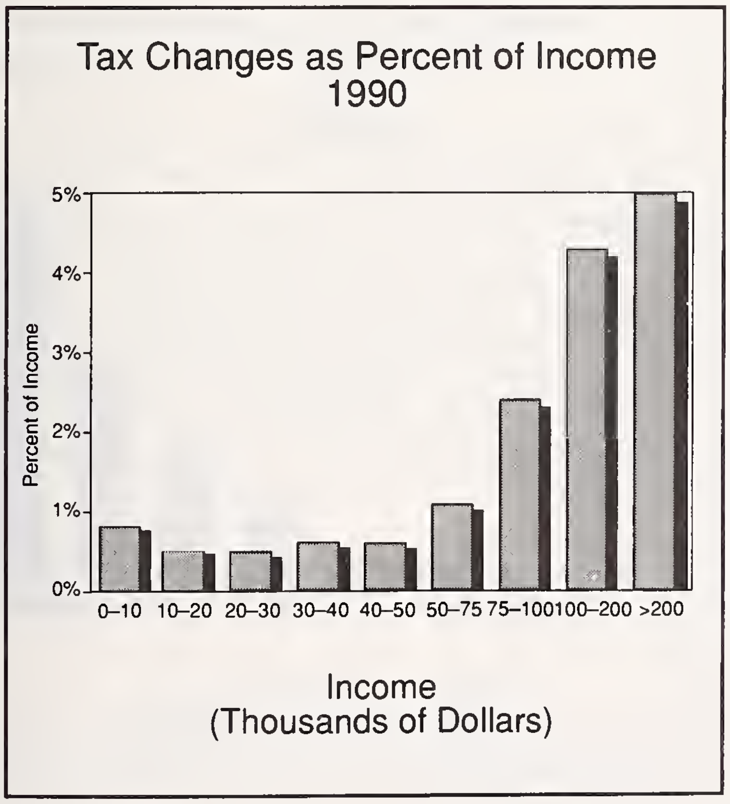
NOTE: Average tax change for the over $200,000 income class is $18,537.

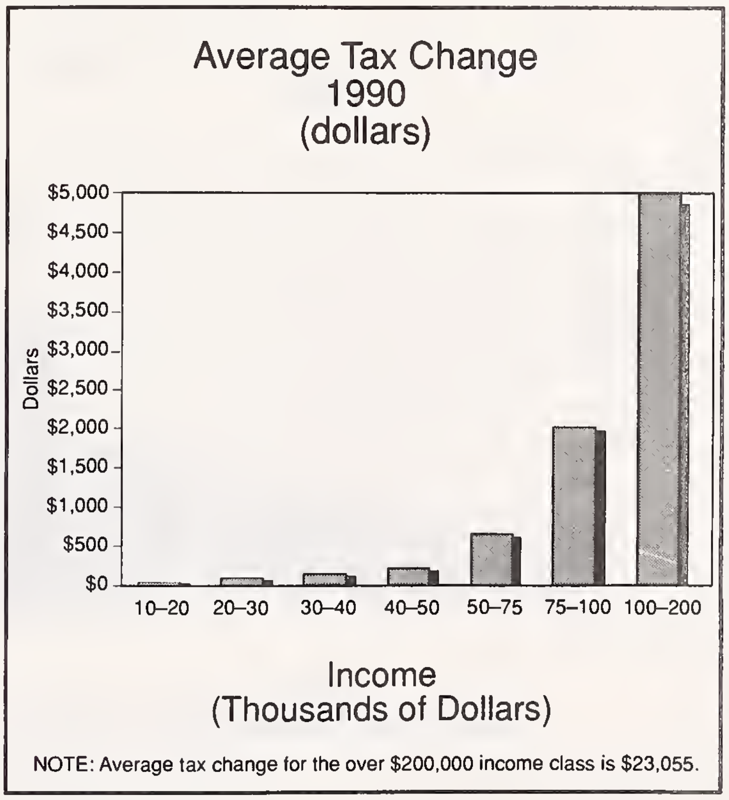
*NOTE: Distribution presented without capital gains behavioral response. That response is unallocated in the distribution but is allocated to the totals. For further notes, see Figure F-1.

SOURCE: Price Waterhouse

Figure F-5—Option V*

Income Class	Returns (thousands)	Cumulative Share of Total Returns	Distribution of: Tax Change as a Percentage of Income	Distribution of: Average Tax Change (dollars)
$0–10,000	27,292	23.4%	0.8%	$42
10,000–20,000	27,938	47.3	0.5	72
20,000–30,000	18,952	63.5	0.5	128
30,000–40,000	13,382	75.0	0.6	199
40,000–50,000	9,169	82.8	0.6	249
50,000–75,000	12,086	93.2	1.1	662
75,000–100,000	4,242	96.8	2.4	2,020
100,000–200,000	2,881	99.3	4.3	5,681
over 200,000	827	100.0	5.0	23,055
Total	116,769		1.8%	$579





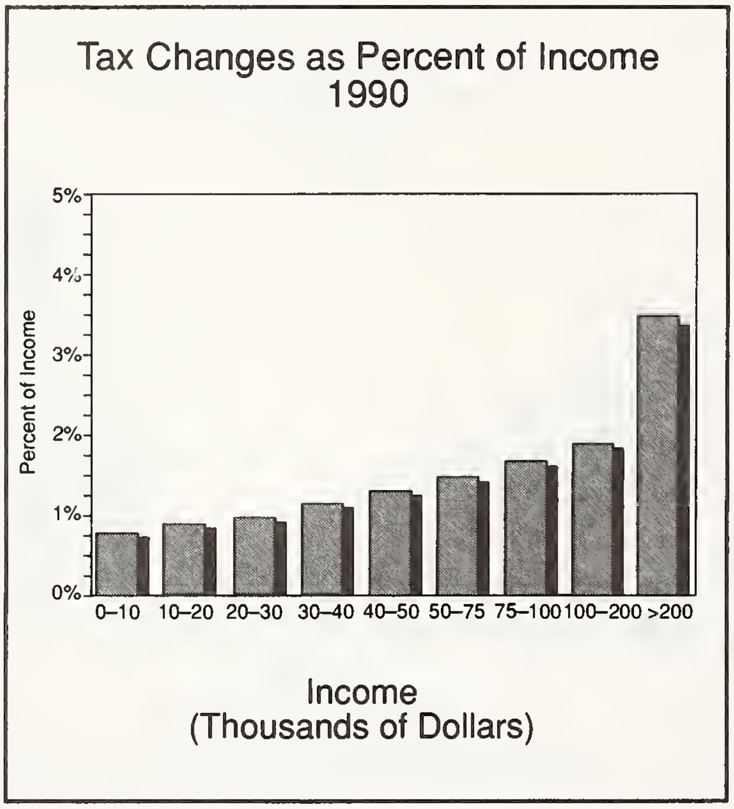
NOTE: Average tax change for the over $200,000 income class is $23,055.

*NOTE: Some $5.1 billion, or 7.4 percent of the total revenue raised, is unallocated in the distribution but allocated in the totals. For further notes, see Figure F-1.

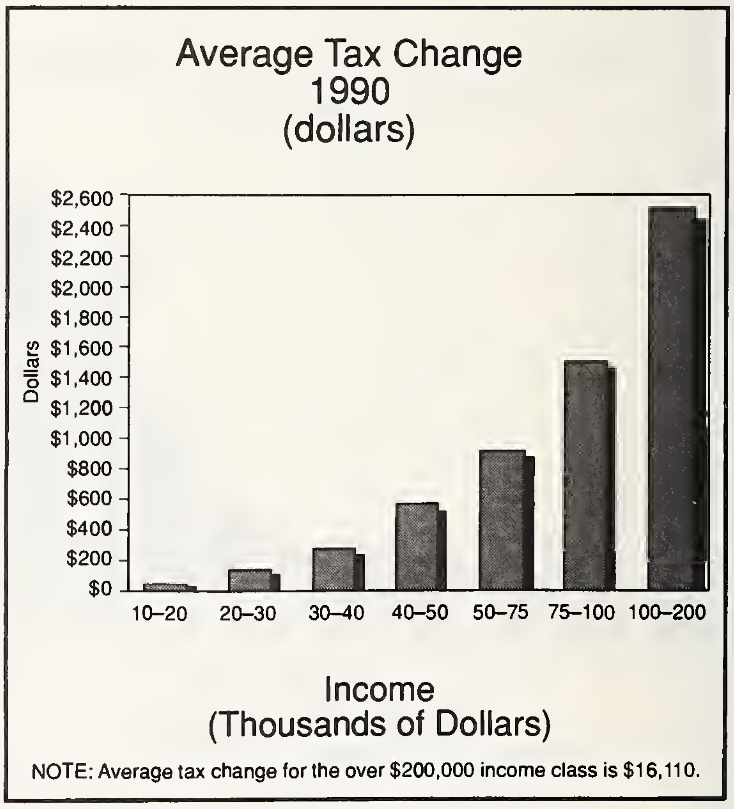
SOURCE: Price Waterhouse

Figure F-6—Option VI*

Income Class	Returns (thousands)	Cumulative Share of Total Returns	Distribution of: Tax Change as a Percentage of Income	Distribution of: Average Tax Change (dollars)
$0–10,000	27,292	23.4%	0.8%	$41
10,000–20,000	27,938	47.3	0.9	130
20,000–30,000	18,952	63.5	1.0	255
30,000–40,000	13,382	75.0	1.2	425
40,000–50,000	9,169	82.8	1.3	591
50,000–75,000	12,086	93.2	1.5	919
75,000–100,000	4,242	96.8	1.7	1,470
100,000–200,000	2,881	99.3	1.9	2,507
over 200,000	827	100.0	3.5	16,110
Total	116,769		1.7%	$545



Tax Changes as Percent of Income
1990



Average Tax Change
1990
(dollars)

NOTE: Average tax change for the over $200,000 income class is $16,110.

*NOTE: Some $5.1 billion, or 8.1 percent of the total revenue raised, is unallocated in the distribution but allocated in the totals. For further notes, see Figure F-1.
SOURCE: Price Waterhouse

EXHIBIT 1: EXAMPLES OF TAXPAYER BURDENS

Within any income category, changes in tax liabilities can also vary depending upon the specific circumstances of different households. To further illustrate the impact of various options, a number of example households have been created and are described below. They were chosen to illustrate the range of impacts, but obviously many other variations are also possible. The options listed are defined in Table F-2.

In most cases, the major differences in how these sample households fare under various options are traceable to the options' varying progressivity. In particular, they tend to reflect the differences in the major revenue source in each option (e.g., the payroll tax versus the value added tax, or VAT).

Since Options 5 and 6 each assume that some of the revenues needed to finance the package would come from a reordering of existing budget priorities, they increase tax liabilities by less than the other options. Option 5 assumes $5 billion comes from these existing sources, and Option 6 assumes that $10 billion would be raised in this way.

Young Single Mother With Two Children
Income: $7,800

Like many other families headed by single mothers, our example family has an income well below the poverty line. We assume that the mother works 30 hours per week at $5 per hour and earns $7,800 in 1990. This is her only source of income. Although the family income is below the poverty line ($10,560), it is still too high for them to qualify for Medicaid in the state where she lives. This family would receive full health care benefits under the Pepper Commission proposal.

Estimated Increase in Tax Liabilities Under Each of the Six Options:

Option 1	$ 0	Option 4	$ 0
Option 2	212	Option 5	0
Option 3	0	Option 6	125

Under most of these options, this family would owe no new taxes, because of its very low income. The payroll tax accounts for the tax burden in Option 6; there is no such burden from Option 1, which also raises the payroll tax, because of an offsetting increase in the earned income tax credit. Option 2 is the least desirable to this family, because of the relative regressivity of the value added tax.

High Income Couple With No Children
Income: $225,000

Couples with professional or managerial jobs can earn enough together to achieve very high incomes. The couple in this example are assumed to earn $90,000 and $75,000 at their full time jobs. Since they have had such high incomes for a number of years, they also have accumulated considerable assets that enable them to receive $60,000 in income from investments. Their total income is $225,000. This couple saves a considerable share of their incomes each year. They also are heavy consumers of beer and wine. They are assumed to each have generous health care benefits from their employers.

Estimated Increase in Tax Liabilities Under Each of the Six Options:

Option 1	$5,456	Option 4	$ 8,910
Option 2	2,847	Option 5	11,622
Option 3	6,606	Option 6	4,954

Tax liability increases for this high income family vary substantially—a difference between the highest and the lowest of over $8,700. Option 5, with its very progressive benefits, raises both the payroll tax and the income surtax. Even this couple's high income, after deductions, is too low to be affected by the increase in the top rate from 28 percent in Options 1, 2 and 3. The gross income tax of Option 4 also places a heavy burden on this family because it would tax all income, allowing no deductions. At the low end, the value added tax in Option 2 increases taxes for the family by much less than the payroll tax increase in Option 1 or the income surtax in Option 3.

Moderate Income Elderly Couple
Income: $38,000

Retired families that are relatively well off generally have both pension income and income from interest or property that supplements their Social Security benefits. This couple is assumed to have total income of $38,000, $15,000 of which comes from Social Security and the rest from pension and interest income. One of them is a smoker and the husband's former employer pays the premiums on a modest supplemental policy to Medicare. This couple would primarily benefit from the long term care benefits in the Pepper Commission proposal.

Estimated Increase in Tax Liabilities Under Each of the Six Options:

Option 1	$ 348	Option 4	$ 495
Option 2	1,801	Option 5	122
Option 3	1,622	Option 6	281

The difference in the tax liabilities under these options would be quite dramatic, largely because of the lowering of the threshold used to tax Social Security in Options 2 and 3. The couple's income is at a level that makes them particularly sensitive to the threshold change. In Options 1 and 6, only the rate of taxation of Social Security would change. The couple would also be subjected to substantial increase in liabilities from the value added tax under Option 2. Because both these individuals are retired, they would pay no payroll tax, resulting in low liabilities in Options 1, 5 and 6.

Moderate Income Couple With Two Children
Income: $30,000

This family has an income of $30,000 a year, most of which ($28,000) comes from the husband's earnings. This income level puts the family in the middle of the income range for households in the United States. Like many other young families with children, the family has only a small amount of additional income from savings. The couple drinks moderately and has health insurance coverage in which the husband's employer contributes about half of the cost. The employer's share of insurance premiums would rise under the Pepper Commission proposal and relieve the family of some of its burden to pay for the premiums.

Estimated Increase in Tax Liabilities Under Each of the Six Options:

Option 1	$601	Option 4	$135
Option 2	512	Option 5	143
Option 3	241	Option 6	448

Unlike the examples for higher income families, for this family Option 1 would raise taxes the most. The large payroll tax increase is more significant for this family than a value added tax or the income surtax. As consumers of alcohol, they would also have additional liabilities in Options 1, 3 and 5. Options 4 and 5 are the most progressive and result in the lowest increase in taxes for this moderate income family.

Poor Elderly Widow
Income: $5,500

Elderly women living alone, like younger women heading households, often have extremely low incomes. In this example, we assume the widow has a total income of $5,500, $4,000 of which comes from her Social Security benefits. She has an additional $1,500 in income from her savings. We assume she cannot afford to either drink or smoke. She would benefit from improvements in Medicare that would help pay for her deductibles, coinsurance and Part B premium. She would also receive full protection against long-term care needs under the Pepper Commission proposal.

Estimated Increase in Tax Liabilities Under Each of the Six Options:

Option 1	$ 0	Option 4	$ 0
Option 2	98	Option 5	0
Option 3	0	Option 6	0

Under five of the options presented here, this widow would not owe any additional tax. Her income is low, she has no earnings and she does not drink or smoke. She would, however, owe $98 for the 4 percent value added tax if Option 2 were chosen.

Low Income Single Worker
Income: $12,000

Many young people starting out rely on earnings for all of their income. Our young worker in this example has $12,000 in earnings and no other sources of income. We assume that this individual smokes and drinks. At that level of income, the worker is unlikely to have much, if any, insurance paid for by his employer. Consequently, he would benefit from the Pepper Commission proposal by receiving an 80 percent premium subsidy from his employer.

Estimated Increase in Tax Liabilities Under Each of the Six Options:

Option 1	$373	Option 4	$ 0
Option 2	266	Option 5	175
Option 3	215	Option 6	192

In addition to owing additional taxes on cigarettes and beer under Options 1, 3 and 5, our single worker would be strongly affected by the value added tax. The payroll tax increases in Options 1 and 6 would also be substantial. The combination of excise and payroll taxes in Option 1 make it the least desirable option from this worker's perspective. Since his income is low and it is all from wages, the income surtax would be lower for this individual under Options 3 and 5, and he would pay no gross income tax under Option 4 since his income is below the exempt amount.

Upper Middle Income Couple With One Child
Income: $80,000

This family, with a total income of $80,000, is well above average in the United States. We assume that both husband and wife work, but the wife does so only part-time. Consequently, their salaries are $60,000 and $15,000, respectively. They have some savings, giving them an additional $5,000 in interest income each year. We assume that they are moderate drinkers and that one smokes. Such a family would likely have good employer-provided insurance through the husband's job. This family would benefit from the Pepper Commission long-term care proposal in two ways: they would have their own insurance, and if one of the parents of the couple had moderate income and was in need of long-term care, some of their potential financial burdens would be eased.

Estimated Increase in Tax Liabilities Under Each of the Six Options:

Option 1	$1,876	Option 4	$2,385
Option 2	1,907	Option 5	1,910
Option 3	2,056	Option 6	1,591

The variation in new taxes across the options would not be as great for this family as compared to some of the others. They would owe more in FICA taxes under Option 1 than from the income surtax of Option 3 or the VAT in Option 2, but eliminating the Social Security taxable maximum and capping employer paid health insurance premiums would raise the liabilities under Options 2 and 3 in line with that for Option 1. This family would face the greatest increase in new taxes from Option 4, the gross income tax of 4.5 percent, and the lowest from Option 6, which combines an income and payroll tax change—and assumes a $10 billion reduction in other spending.

Well-Off Elderly Couple
Income: $200,000

A small number of older families have very high incomes in the United States. In this example we assume the couple has an income of $200,000 from a number of sources. The wife is still working and earns a salary of $70,000. The husband, a retired executive, gets $9,000 in Social Security benefits and $21,000 from his pension. In addition, the couple has $100,000 from rent on property they own and from other investments. We assume that they neither smoke nor drink, and that the wife and husband each have employer paid health insurance. This couple would benefit only from a part of the Pepper Commission long-term care proposal: the home care and "front-end" nursing home benefit portions.

Estimated Increase in Tax Liabilities Under Each of the Six Options:

Option 1	$2,912	Option 4	$7,785
Option 2	4,131	Option 5	4,175
Option 3	5,568	Option 6	3,684

In this example, the difference in tax liabilities across the various options arises because so much of this family's income comes from sources other than earnings. Consequently, the payroll tax increases are considerably less important to this couple. For example, the income surtax in Option 3 is about two and a half times larger than the payroll tax increase in Option 1. The largest impact on this couple would come from the gross income tax in Option 4. In addition, this couple would be strongly affected by the cap on employer health insurance payments.

Notes for Appendix F

1. Prepared by Marilyn Moon of the Urban Institute, with assistance from Commission staff. Tax distribution and estimated tax liability changes by Price Waterhouse.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1990-286-134/21280

CMS LIBRARY
3 8095 00015232 8